

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 5 4 6 9  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>GRACE R ADKINS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 22 83</b>  |  | 2b. HOUR <b>9 A M</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 9 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>EASTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Talbot</b>   |  | 13c. CITY OR TOWN <b>Easton</b>  |  | 13e. STREET ADDRESS <b>607 Windmill Road 21601</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Rathbone</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Olcott</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>040-38-4932</b>   |  | 17. INFORMANT ADDRESS <b>William H. Adkins, II Easton, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4149</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-22-83</b> 19 <b>83</b> , to <b>2-22-83</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>2-22-83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Thomas Fauntleroy, M.D.</b> DEGREE <b>M.D.</b>  |  |   |  | 22c. DATE SIGNED <b>2/23/83</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Fauntleroy, M.D.</b>  |  |
| 22e. ADDRESS <b>Easton, Md. 21601</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>2-23-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes Sussex Del.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b> ADDRESS <b>Easton, Md. 21601</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   | 8 3 0 5 4 7 0                                   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
|---|--|--|---|--|--|---|--|--|---|---|-----------------|-----------------------|-------|-----------------------------------|-----------------|-----|--|--------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | REG. NO.  |  |  |   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE  |  |  | LAST  |   |                 | 2a. DATE OF DEATH     |       | MONTH                             |                 | DAY |  | YEAR               |  | 2b. HOUR |  |
| Constance Kennedy Anderson  |  |  |   |  |  |   |  |  |   |   |                 | FEBRUARY 2 1983       |       |                                   |                 |     |  | 4:45P <sup>M</sup> |  |          |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   |                 | IF UNDER 1 YEAR       |       |                                   | IF UNDER 24 HRS |     |  |                    |  |          |  |
| Female  |  |  | Caucasian   |  |  | FEB. 20 <sup>DAY</sup> 1909 <sup>YEAR</sup>   |  |  | 73  |   |                 | MONTHS                |       |                                   | DAYS            |     |  | HOURS              |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| New Jersey  |  |  | U.S.A.  |  |  |   |  |  | Talbot  |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| Easton  |  |  | R.D. 6, Box 132   |  |  | Housewife   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |   |  |  |   | 13d. INSIDE CITY LIMITS?                        |                 | 13e. STREET ADDRESS   |       |                                   |                 |     |  |                    |  |          |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | R.D. 6, Box 132 |                       | 21601 |                                   |                 |     |  |                    |  |          |  |
| Md.   |  |  | Talbot  |  |  | Easton  |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| FIRST   |  |  | MIDDLE  |  |  | LAST  |  |  | FIRST   |   |                 | MIDDLE                |       |                                   | LAST            |     |  |                    |  |          |  |
| Arthur  |  |  | Kennedy   |  |  | Anne  |  |  | Listenberger  |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| No  |  |  | 214-34-7377   |  |  | Larz K. Anderson  |  |  | Dallas, Texas   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Bilateral pneumonia &amp; respiratory failure</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Epithelioid cell Ca RLL &amp; metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>disease to liver</u><br>(c) <u></u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>ASCD &amp; hypertension + COPD + Diabetes mellitus</u> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                 | 1 week                |       | 3 months                          |                 |     |  |                    |  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19  |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |   |                 | COUNTY                |       |                                   | STATE           |     |  |                    |  |          |  |
|   |  |  |   |  |  |   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 21</u> , 19 <u>83</u> , to <u>2/2</u> , 19 <u>83</u> , that (I) (we) last<br>saw the deceased alive on <u>2/2</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   | 22b. SIGNATURE<br><u>Albert T. Dawkins, Jr.</u> |                 | DEGREE<br><u>M.D.</u> |       | 22c. DATE SIGNED<br><u>2/3/83</u> |                 |     |  |                    |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| Albert T. Dawkins, Jr., M.D.  |  |  | Easton, Md.   |  |  |   |  |  |   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN                                       |   |                 | COUNTY                |       |                                   | STATE           |     |  |                    |  |          |  |
| Cremation   |  |  | 2-3-83  |  |  | Delmarva Crematory  |  |  | Lewes   |   |                 | Sussex                |       |                                   | Del             |     |  |                    |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |
| Newnam Funeral Home   |  |  | Easton, Md.   |  |  | FEB 9 1983  |  |  | <u>John J. Connel</u>   |   |                 |                       |       |                                   |                 |     |  |                    |  |          |  |



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# FOR STATE HEALTH DEPT.

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 5 4 7 1

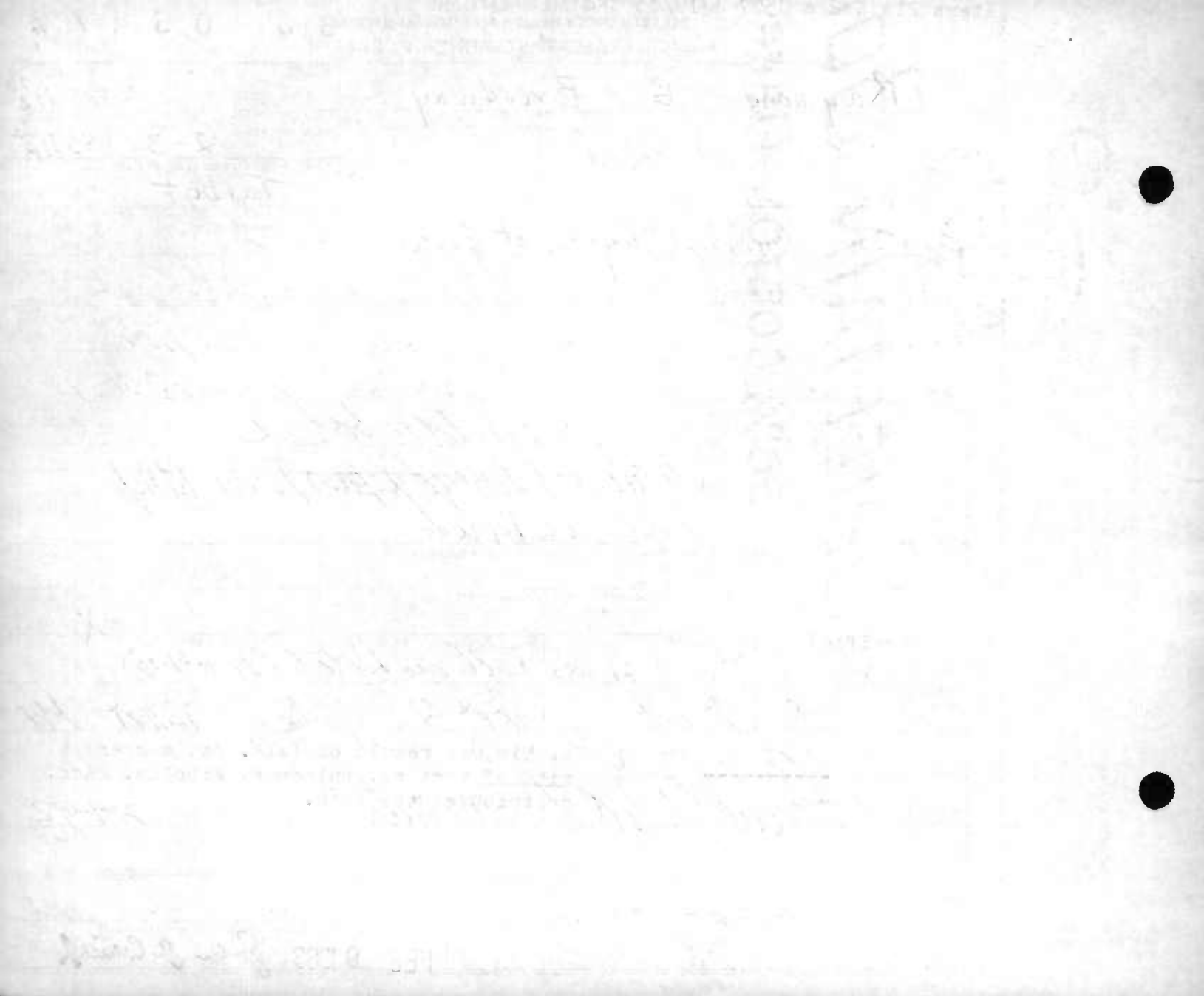
|   |  |         |                   |  |  |   |  |   |                |                 |  |  |  |  |  |
|---|--|---------|-------------------|--|--|---|--|---|----------------|-----------------|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  |         | First Middle Last |  |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-<br>DEATH MATED <input type="checkbox"/> |  |   | Month Day Year |                 |  | 2b. HOUR   |  |  |  |
| Greely Irvin Ball   |  |         |                   |  |  | FEB 26 1983   |  |   | 7:16 P         |                 |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |                   | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |                | IF UNDER 24 HRS |  | 2c. DATE PRONOUNCED DEAD                                 |  |  |  |
| Male  |  | White   |                   | SEPT. 6, 1923  |  | 59 YRS.   |  | MONTHS DAYS   |                | HOURS MIN.      |  | Month Day Year 19 M                                      |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                 |  | 9. COUNTY OF DEATH                                       |  |  |  |
| Maryland  |  |         |                   | U.S.A.   |  |   |  | Talbot  |                |                 |  | Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                |                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |
| Easton  |  |         |                   | Memorial Hospital  |  |   |  | Waterman  |                |                 |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |                   | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN   |                |                 |  | 13d. INSIDE CITY LIMITS?                                 |  |  |  |
| Md.   |  |         |                   | Talbot   |  |   |  | Bozman  |                |                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME   |  |         |                   | 15. MOTHER'S MAIDEN NAME   |  |   |  | 13e. STREET AND NUMBER  |                |                 |  |  |  |  |  |
| Greely Nathaniel Ball   |  |         |                   | Emma Newnam  |  |   |  | Route 579 21612   |                |                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         |                   | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT   |                |                 |  | ADDRESS  |  |  |  |
| Yes   |  |         |                   | WW II  |  |   |  | 219-18-9380   |                |                 |  | Betty Jane Ball Bozman, Md.                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture Coronary Artery</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>A.S.C.V.D.</u>  |  |         |                   |  |  |   |  |   |                |                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |                   |  |  |   |  |   |                |                 |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |  |   |                |                 |  | 20. AUTOPSY?   |  |  |  |
|   |  |         |                   |  |  |   |  |   |                |                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                |                 |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |         |                   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                |                 |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |         |                   |  |  |   |  |   |                |                 |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Louis S. Welty</u>  |  |         |                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                |                 |  | 22b. DATE SIGNED   |  |  |  |
| EXAMINER'S NAME (Type) Louis S. Welty, M.D.   |  |         |                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |   |  | ADDRESS (Street, city, town, or county)   |                |                 |  | 2-28-83  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         |                   | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                |                 |  | 23d. LOCATION (City or Town) (County) (State)            |  |  |  |
| Burial  |  |         |                   | 3-1-83   |  |   |  | Woodlawn Memorial Park  |                |                 |  | Easton Talbot Md   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |                   | ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR   |                |                 |  | 25b. REGISTRAR'S SIGNATURE                               |  |  |  |
| Newnam Funeral Home   |  |         |                   | Easton, Md.  |  |   |  | MAR 3 1983  |                |                 |  | <u>Jo Ann J. Connel</u>                                  |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                       |  |  |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |   |  |   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                    |  |  |  |  |  |  |  | REG. NO. |  |
|--|--|-----------------------|--|--|--|--|--|---|--|---|--|---|--|--|--|---|--|---|--|---|--|------------------------------------|--|--|--|--|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: <u>Raymond</u> MIDDLE: <u>G</u> LAST: <u>Broadway</u>   |  |                       |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH: <u>2</u> DAY: <u>3</u> YEAR: <u>1983</u>        |  |   |  |  |  |   |  |   |  | 2b. HOUR: <u>11</u> MIN: <u>20</u>      |  |                                    |  |  |  |  |  |  |  |          |  |
| 3. SEX<br><u>male</u>  |  | 4. RACE<br><u>BLK</u> |  | 5. DATE OF BIRTH<br>MONTH: <u>1</u> DAY: <u>10</u> YEAR: <u>32</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>51</u> YRS.  |  | IF UNDER 1 YR.<br>MONTHS: _____ DAYS: _____   |  | IF UNDER 24 HRS.<br>HOURS: _____ MIN: _____                                       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH: <u>2</u> DAY: <u>3</u> YEAR: <u>1983</u>                                   |  |  |  |   |  |   |  |   |  | 7d. HOUR: <u>11</u> MIN: <u>20</u> |  |  |  |  |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>md</u>   |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Talbot</u>   |  |  |  |   |  |   |  |   |  | MD.                                |  |  |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><u>Easton</u>   |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Memorial Hospital at Easton</u> |  |  |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Cook</u>                                  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 13a. STATE<br><u>md</u>  |  |                       |  | 13b. COUNTY<br><u>Talbot</u>   |  |  |  | 13c. CITY OF TOWN<br><u>Easton</u>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  | 13e. STREET ADDRESS<br><u>54 Janite st</u>  |  |   |  | 21601                                   |  |                                    |  |  |  |  |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST: <u>James</u> MIDDLE: _____ LAST: <u>Broadway</u>   |  |                       |  |  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: <u>Clara</u> MIDDLE: _____ LAST: <u>Taylor</u> |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><u>Yes</u>  |  |                       |  | 16b. SOCIAL SECURITY NO.<br><u>486050</u>  |  |  |  | 17. INFORMANT<br><u>Clara Broadway</u>  |  |   |  | ADDRESS   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <u>Status Post Surgical Repair Fracture Right Hip</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fall in Ditch</u> |  |                       |  |  |  |  |  |   |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                       |  |  |  |  |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |                       |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 21a. EXTERNAL CAUSE OF DEATH<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |                       |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. <u>1</u> <u>21</u> <u>1983</u> |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>Fell in Ditch (Drunk)</u> |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                       |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><u>Street</u>             |  |   |  |   |  | 21f. LOCATION<br>STREET: <u>Port St.</u> CITY OR TOWN: <u>Easton</u> COUNTY: <u>Talbot</u> STATE: <u>MD</u>   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held them, and that death resulted from _____ Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> or post op. pulmonary embolus. Acc. contributed to death.  |  |                       |  |  |  |  |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| ACTUAL SIGNATURE<br><u>George A. Dashiell</u>  |  |                       |  |  |  | M.D. <u>Talbot</u>   |  |   |  |   |  | MEDICAL EXAMINER  |  |  |  |   |  | DATE SIGNED <u>2-4-83</u>   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                       |  |  |  | ADDRESS  |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                       |  |  |  | 23b. DATE<br><u>2/7/83</u>   |  |   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Richardson</u>   |  |  |  |   |  | 23d. LOCATION<br>CITY OR TOWN: <u>Easton</u> COUNTY: <u>Talbot</u> STATE: <u>MD</u> |  |   |  |                                    |  |  |  |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME: <u>George A. Dashiell</u> ADDRESS: <u>Easton MD</u>  |  |                       |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 9 1983</u>                                       |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |  |  |  |  |          |  |





4

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |  |   |   |                                       |   |  | REG. NO. 3 0 5 4 7 3  |  |
|--|-------------------------|--|---|--|---|---|---------------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Craig Bundick</b>   |                         |  |   |  |   |   |                                       |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>1983</b>  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>65</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>17</b> YRS. | IF UNDER 1 YR.<br>MONTHS<br><b>17</b>  | IF UNDER 24 HRS.<br>DAYS<br><b>17</b>   | IF UNDER 24 HRS.<br>HOURS<br><b>17</b>  | IF UNDER 24 HRS.<br>MIN.<br><b>17</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>1983</b>             |  | 2b. HOUR<br><b>3:32</b> AM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.   |                                       |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                                   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                                    |  |   |  |
| 13a. STATE<br><b>VA.</b>   |                         | 13b. COUNTY<br><b>Accomack</b>   |   | 13c. CITY OR TOWN<br><b>Accomack</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                                       | 13e. STREET ADDRESS<br><b>BOX 148 99999</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>Godwin</b> LAST <b>Godwin</b>   |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARGARET</b> MIDDLE <b>Bundick</b> LAST <b>Bundick</b> |   |                                       |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>231-11-7108</b>   |   | 17. INFORMANT ADDRESS<br><b>Robert Godwin - Accomack, VA.</b>  |   |   |                                       |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8147</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b>Skull Fracture</b><br>(c) <b>Brainstem - Multiple Fractures</b> |                         |  |   |  |   |   |                                       |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Cerebral Vascular Accident</b>  |                         |  |   |  |   |   |                                       |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:58 PM 2 14 1983</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Struck by Tractor Trailer</b> |                                       |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Highway</b>  |   | 21f. LOCATION<br>STREET <b>Onley</b> CITY OR TOWN <b>Onley</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>       |                                       |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                         |  |   |  |   |   |                                       |   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br><b>R. Lane Wroth</b>   |                         |  |   | TITLE (SPECIFY)<br><b>M.D. Deputy</b>  |   |   |                                       | DATE SIGNED<br><b>2-15-83</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>R. Lane Wroth, M.D.</b>  |                         |  |   | ADDRESS<br><b>Talbot St. St. Michaels, Md. 21663</b>   |   |   |                                       |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2-19-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Accomack Cem.</b>   |   |   |                                       | 23d. LOCATION<br>CITY OR TOWN <b>Accomack</b> COUNTY <b>Accomack</b> STATE <b>VA.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Keith G. Wroth</b> ADDRESS <b>Accomack, VA.</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Joan G. Carrier</b>  |                                       |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8305474

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |   |   |  |
|---|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George Leslie Callaway</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-1-1983</b>                    |   |   | 2b. HOUR<br><b>2:22 P</b>  |   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 16, 1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                            |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital at Easton</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FAA</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>USGovt.</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Talbot</b>   |   | 13c. CITY OR TOWN<br><b>Easton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>Dutchman's Lane</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Callaway</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Callaway</b>              |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-44-6722</b>                         |   | 17. INFORMANT<br>ADDRESS <b>St. Michaels, Md.</b><br><b>G. Leslie Callaway, Jr.</b> |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MALIGNANT LYMPHOMA</b><br><b>2028</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>PRES</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>H.E. ISAMER</b>  |  |   |  |   | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>2.2.83</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H.E. ISAMER</b>   |  |   |  |   | 22e. ADDRESS<br><b>MEMORIAL HOSPITAL - EASTON, MD.</b>                              |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>Feb 3, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG Maryland</b>                      |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James E. Leonard</b>   |  |   |  |   | ADDRESS<br><b>St. Michaels, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1983</b>   |   |   |  |
|   |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                 |  |   |   |   |  |

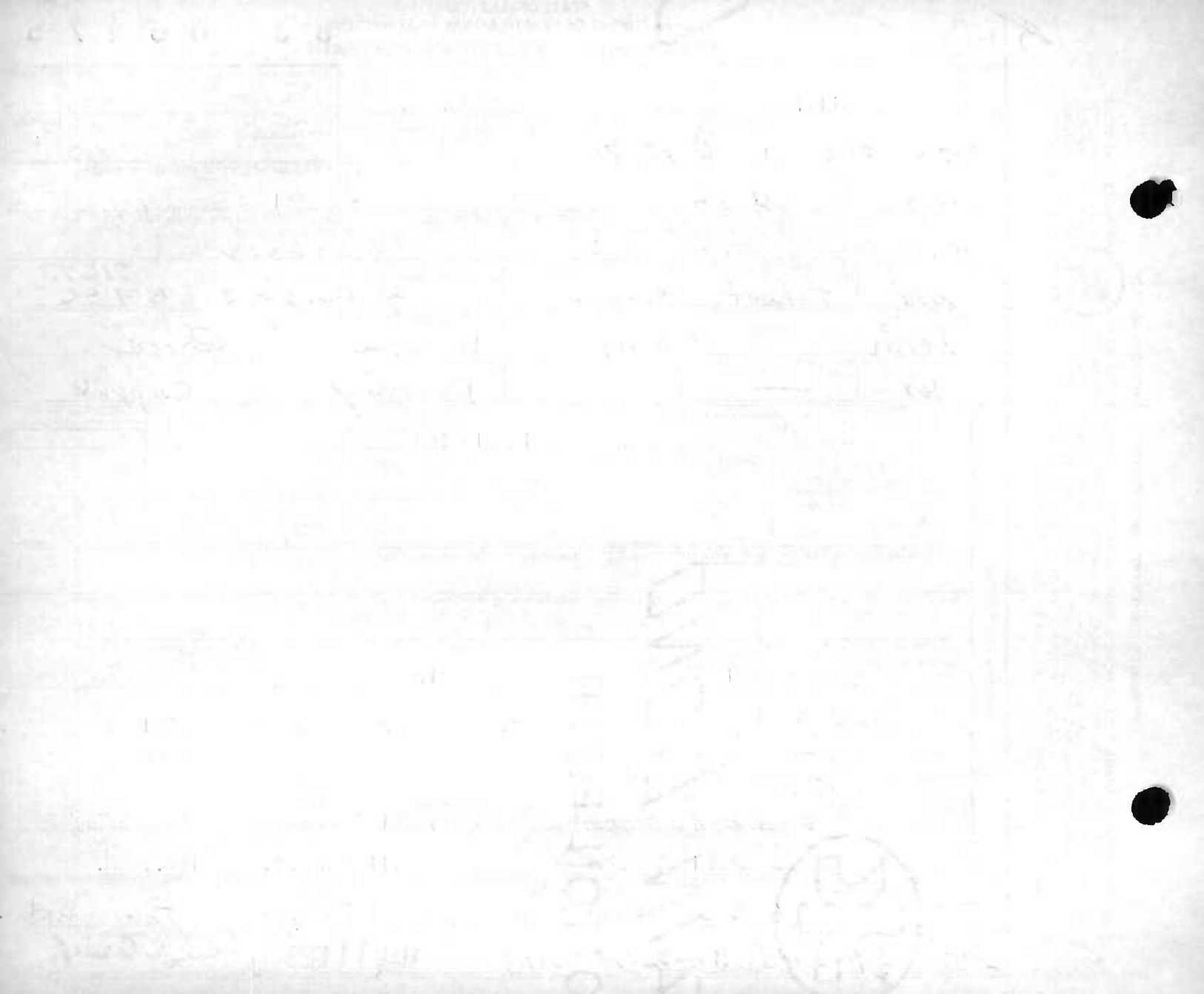
BP \_\_\_\_\_



|   |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
|---|--|---------|--|--|--|------------------------------------|--|---|--|--------------------------|--|--------------------------------------|--|---|--|------------------|--|--------------------------|--|-------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST                               |  | 2a. DATE KNOWN<br>OF DEATH  |  | ESTI-<br>MATED           |  | MONTH                                |  | DAY   |  | YEAR             |  | 2b. HOUR                 |  |             |  |
| William   |  | Lee     |  | Camper   |  |                                    |  | 2   |  | 26                       |  | 19                                   |  | 83  |  |                  |  |                          |  |             |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.         |  | 7c. DATE<br>PRONOUNCED<br>DEAD       |  | MONTH   |  | DAY              |  | YEAR                     |  | 2d. HOUR    |  |
| male  |  | B/K     |  | 1 6 12 71  |  | YRS.                               |  | MONTHS  |  | DAYS                     |  | HOURS                                |  | MIN.  |  | 2                |  | 26                       |  | 19 83 9:20  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |                  |  |                          |  |             |  |
| MD  |  |         |  | USA  |  |                                    |  |   |  |                          |  | Talbot County, MD                    |  |   |  |                  |  |                          |  |             |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |                          |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |   |  |                  |  |                          |  |             |  |
| Trappe  |  |         |  | Rt. #2, Box 56   |  |                                    |  | Laborer   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| 13a. STATE  |  |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS      |  | 21673 Route # 2 Bq 5L                |  |   |  |                  |  |                          |  |             |  |
| MD  |  |         |  | Talbot   |  | Trappe                             |  | YES   |  | Route # 2                |  |                                      |  |   |  |                  |  |                          |  |             |  |
| 14. FATHER'S NAME   |  |         |  | FIRST  |  | MIDDLE                             |  | LAST  |  | 15. MOTHER'S MAIDEN NAME |  |                                      |  | FIRST   |  | MIDDLE           |  | LAST                     |  |             |  |
| Levin   |  |         |  |  |  |                                    |  | Camper  |  | Heretta                  |  |                                      |  |   |  | Green            |  |                          |  |             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.   |  |                                    |  | 17. INFORMANT   |  |                          |  | ADDRESS                              |  |   |  |                  |  |                          |  |             |  |
| No  |  |         |  |  |  |                                    |  | Dorothy   |  |                          |  | Copper                               |  |   |  |                  |  |                          |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u><br>8902<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                    |  |   |  |                          |  |                                      |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |                          |  |             |  |
|   |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY<br>HOUR <u>9:17</u> P.M. MONTH <u>2</u> DAY <u>26</u> YEAR <u>19 83</u>                |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>House fire   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home                                     |  |                                    |  | 21f. LOCATION<br>STREET<br>Rt. #2, Box 56   |  |                          |  | CITY OR TOWN<br>Trappe               |  |   |  | COUNTY<br>Talbot |  |                          |  | STATE<br>MD |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |
| ACTUAL<br>SIGNATURE   |  |         |  | TITLE (SPECIFY)<br>M.D. Deputy Chief   |  |                                    |  |   |  |                          |  |                                      |  | MEDICAL EXAMINER  |  |                  |  | DATE<br>SIGNED 2/28/83   |  |             |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |         |  | Thomas D. Smith, M.D.  |  |                                    |  |   |  |                          |  |                                      |  | ADDRESS   |  |                  |  | 111 Penn St. Balto., MD. |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |         |  | 23b. DATE  |  |                                    |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION<br>CITY OR TOWN        |  |   |  | COUNTY           |  |                          |  | STATE       |  |
| 1   |  |         |  | 3/2/83   |  |                                    |  | Paradise Con  |  |                          |  | Trappe                               |  |   |  | TA - MD          |  |                          |  |             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry H. Deshler<br>ADDRESS<br>250. DATE REC'D. BY REGISTRAR<br>MAR 11 1983<br>25b. REGISTRAR'S SIGNATURE<br>John J. Smith  |  |         |  |  |  |                                    |  |   |  |                          |  |                                      |  |   |  |                  |  |                          |  |             |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, 3, 4 AND 5 TO THE FUNERAL DIRECTOR. THE CHIEF MEDICAL EXAMINER, WITH FORM PA-1, SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 7 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward T CARROLL</b>                 |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 15 1983</b> |   |  | 2b. HOUR <b>12</b> MIN <b>30</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Blk</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 18 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.                                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALbot</b> MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>waterman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. CITY OR TOWN<br><b>Brownsville</b>                     |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br><b>P.O. Box 9 21638</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George H Carroll</b>              |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fluores</b>                      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> |  |   |   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Edward Carroll Jr.</b>     |  |  |
| 16c. IF YES, GIVE WAR OR DATES   |  |   |   |   | ADDRESS  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4850**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**2/4/83**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**CONGESTIVE HEART FAILURE**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **2/14/83**, 19\_\_\_\_, to **2/15/83**, 19\_\_\_\_, that (I) (we) last saw the deceased alive on **2/14/83**, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

**CARW BAIN**

DEGREE

**MD**ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

**2/15/83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**CARW BAIN**

22e. ADDRESS

**Easton, Md**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

**2/19/83**

23c. NAME OF CEMETERY OR CREMATORY

**Robinson**23d. LOCATION  
CITY OR TOWN**Brownsville GA**

COUNTY

STATE

**MD**

24. FUNERAL DIRECTOR

NAME

**Samuel D. Calhoun Jr. MD**

ADDRESS

25a. DATE REC'D. BY REGISTRAR

**FEB 16 1983**

25b. REGISTRAR'S SIGNATURE

**Samuel D. Calhoun Jr.**

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 7 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |   |  |
|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James A Coleman</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-26-83</b>                 |  | 2b. HOUR<br>4:4 AM  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 21, 1925</b>                             |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hosp. Tal</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                              |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Trucker &amp; Waterman</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. CITY OR TOWN<br><b>Federalsburg</b>                              |  | 13c. STREET ADDRESS<br><b>RD2 Federalsburg 21632</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Lea Coleman</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Skipper</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-20-2870</b>                        |  | 17. INFORMANT<br><b>Mrs. Ruth R. Coleman, Federalsburg, Md.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Probable Acute Myocardial Infarction</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>YES</b> |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <b>1/13</b> 19 <b>82</b> , to <b>2/26</b> 19 <b>83</b> , that (b) (we) last saw the deceased on <b>2/24</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas M. Sp Carney MD</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>2/26/83</b>   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22c. ADDRESS   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar. 1, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dorchester Mem. Park, Cambridge, Dor. Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Thomas M. Sp Carney</b>  |  | ADDRESS<br><b>21613 Camb. Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 - 1983</b>                                   |   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carney</b>                                    |   |  |

BP

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

|             |  |
|-------------|--|
| Case No.    | 100-100000                             |
| Date        | 10-10-1963                             |
| Re          | Letter from [illegible] dated 10-10-63 |
| Subject     | [illegible]                            |
| Reference   | [illegible]                            |
| Disposition | [illegible]                            |
| Remarks     | [illegible]                            |

[illegible handwritten notes and stamps]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |             |  |   |                          |  |      |  |                                      | 8 3 0 5 4 7 8  |         |   |          |                            |                                   |  |
|---|--|-------------|--|---|--------------------------|--|------|--|--------------------------------------|--|---------|---|----------|----------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |             |  |   |                          |  |      |  |                                      | REG. NO.   |         |   |          |                            |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |             | FIRST  |   | MIDDLE                   |  | LAST |  | 2a. DATE OF DEATH MONTH DAY YEAR     |  |         |   | 2b. HOUR |                            |                                   |  |
| Harry   |  |             | E.   |   | Conrad                   |  |      |  |                                      |  | 2-16-83 |   | 11 A M   |                            |                                   |  |
| 3. SEX  |  |             | 4. RACE  |   |                          | 5. DATE OF BIRTH   |      |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |         | IF UNDER 1 YEAR   |          | IF UNDER 24 HRS            |                                   |  |
| Male  |  |             | Caucasian  |   |                          | JAN. 2 DAY 1902  |      |  | 81 YRS                               |  |         | MONTHS DAYS   |          | HOURS MIN.                 |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |             | 7b. CITIZEN OF WHAT COUNTRY?   |   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |         |   |          |                            |                                   |  |
| Maryland  |  |             | U.S.A.   |   |                          |  |      |  | Talbot MD.                           |  |         |   |          |                            |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                          |  |      |  |                                      |  |         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |          |                            | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Easton  |  |             | Memorial Hospital at Easton  |   |                          |  |      |  |                                      |  |         | Carpenter   |          |                            |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |  |   |                          |  |      |  |                                      | 12601  |         |   |          |                            |                                   |  |
| 13a. STATE  |  | 13b. COUNTY |  | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?   |      | 13e. STREET ADDRESS  |                                      |  |         |   |          |                            |                                   |  |
| Md.   |  | Talbot      |  | Easton  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      | R.D. 3, Box 739 C  |                                      |  |         |   |          |                            |                                   |  |
| 14. FATHER'S NAME   |  |             |  |   | 15. MOTHER'S MAIDEN NAME |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| FIRST MIDDLE LAST   |  |             |  |   | FIRST MIDDLE LAST        |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| Carl Conrad   |  |             |  |   | Emma Willis              |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |             |  |   | 16b. SOCIAL SECURITY NO. |  |      |  |                                      | 17. INFORMANT ADDRESS  |         |   |          |                            |                                   |  |
| No  |  |             |  |   | 220-16-9992              |  |      |  |                                      | Joyce A. Royer Easton, Md.                                     |         |   |          |                            |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |             |  |   |                          |  |      |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |         |   |          |                            |                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| IMMEDIATE CAUSE (a)   |  |             |  |   |                          |  |      |  |                                      | 11 YRS   |         |   |          |                            |                                   |  |
| 1850 PROSTATE CANCER  |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| (b)   |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| (c)   |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| 19a. DATE OF OPERATION  |  |             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                          |  |      | 20a. AUTOPSY?  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |   |          |                            |                                   |  |
|   |  |             |  |   |                          |  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |   |          |                            |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                          |  |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |         |   |          |                            |                                   |  |
|   |  |             |  | P.M. 19   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                          |  |      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                      |  |         |   |          |                            |                                   |  |
|   |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-26 19 82, to 2-16 19 83, that (I) (we) last saw the deceased alive on 2-15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |             |  |   |                          |  |      |  |                                      |  |         |   |          |                            |                                   |  |
| 22b. SIGNATURE  |  |             |  |   |                          |  |      | DEGREE   |                                      | 22c. DATE SIGNED   |         |   |          |                            |                                   |  |
| Stephen P. Carney, M.D.   |  |             |  |   |                          |  |      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      | 2-17-83  |         |   |          |                            |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |             |  |   |                          |  |      | 22e. ADDRESS   |                                      |  |         |   |          |                            |                                   |  |
| Stephen P. Carney, M.D.   |  |             |  |   |                          |  |      | Easton, Md. 21601  |                                      |  |         |   |          |                            |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |             |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY   |      |  |                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |         |   |          |                            |                                   |  |
| Burial  |  |             |  | 2-19-83   |                          | Spring Hill  |      |  |                                      | Easton Talbot Md   |         |   |          |                            |                                   |  |
| 24. FUNERAL DIRECTOR NAME   |  |             |  |   |                          |  |      | ADDRESS  |                                      | 25a. DATE REC'D. BY REGISTRAR                                  |         |   |          | 25b. REGISTRAR'S SIGNATURE |                                   |  |
| Newnam Funeral Home   |  |             |  |   |                          |  |      | Easton, Md.  |                                      | FEB 18 1983  |         |   |          | John J. Carney             |                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 7 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DANIEL C. COSTELLO</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>4</b> YEAR <b>83</b>                       |   | 2b. HOUR<br><b>5:45</b> M                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cau</b>   | 5. DATE OF BIRTH<br>MONTH <b>Jan</b> DAY <b>15</b> YEAR <b>1902</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mgr - Farm</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Agr.</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. CITY OR TOWN<br><b>Talbot</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS<br><b>21612</b>            |
| 14. FATHER'S NAME<br>FIRST <b>August</b> MIDDLE <b>Costello</b> LAST <b></b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE <b>Mazzini</b> LAST <b></b>      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-32-2187</b>  |   | 17. INFORMANT<br>ADDRESS <b>Box 237</b><br><b>Elizabeth F. Costello, Bozman, Md.</b>            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral, Pulmonary, Heart Dis.</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Chronic Obstructive Pulmonary Dis.</b> |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-15</b> , 19 <b>83</b> , to <b>4 Feb</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1 Feb</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>R. Lane Wroth, M.D.</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2-5-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. LANE WROTH, M. D.</b>  |   | 22e. ADDRESS<br><b>St. Michaels, Maryland</b>   |   |   |  |

MEDICAL CERTIFICATION

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                        | 23b. DATE<br><b>Feb 7, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Mem. Pk</b> | 23d. LOCATION<br>CITY OR TOWN <b>Easton</b> COUNTY <b>Talbot</b> STATE <b>Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>Harmon E. Leonard</b> ADDRESS <b>St. Michaels</b> |                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1983</b>           | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 277-7835.



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 8 3 0 5 4 8 0   |          |   |  |  |
|---|--|--|--|--|--|--|--|--|--|---|----------|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | REG. NO.  |          |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |   | 2b. HOUR |   |  |  |
| Robert  |  |  | Fulton   |  |  | Craighead  |  |  | 2 6 83   |   |          | 12 <sup>42</sup> P.M.   |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |   |          | IF UNDER 1 YEAR   |  |  |
| Male  |  |  | Caucasian  |  |  | APRIL 14 1954  |  |  | 28   |   |          | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |   |          |   |  |  |
| California  |  |  | U.S.A.   |  |  |  |  |  | Talbot MD.   |   |          |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Easton  |  |  | Memorial Hospital at Easton  |  |  |  |  |  | Assist. Manager Restaurant                                     |   |          |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |   |          | 13d. INSIDE CITY LIMITS?  |  |  |
|   |  |  | Md.  |  |  | Talbot   |  |  | Easton   |   |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 13e. STREET ADDRESS  |  |  | 13f. BOX NO.   |   |          | 13g. ZIP CODE   |  |  |
| John  |  |  | Thomas   |  |  | Craighead  |  |  | Mary   |   |          | Fulton  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS  |   |          |   |  |  |
| No  |  |  | 214-58-3468  |  |  | J. Thomas Craighead  |  |  | Easton, Md   |   |          |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma of Stomach<br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 mos |          |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18   |  |  |  |  |  |  |  |  |  |   |          |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |          |   |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |          |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |          |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |          |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/6 1982 to 2/6 1983, that (I) (we) last saw the deceased alive on 2/6 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |          |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED   |   |          |   |  |  |
| Wm H Wood Sr  |  |  | MD   |  |  |  |  |  | 2/6/83   |   |          |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |  |   |          |   |  |  |
| Wm H Wood Sr  |  |  | EASTON Md  |  |  |  |  |  |  |   |          |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |   |          |   |  |  |
| Cremation   |  |  | 2-7-83   |  |  | Delmarva Crematory   |  |  | Lewes Sussex Del.  |   |          |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE                                     |   |          |   |  |  |
| Newnam Funeral Home   |  |  | Easton, Md.  |  |  | FEB 8 1983   |  |  | John J. Smith  |   |          |   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 05481

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                               |  |   |   |   |  |
|--|--|---|--|---|-------------------------------|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred B. Dallam                   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 2 1983                        |   |                               | 2b. HOUR<br>10:04 AM   |   |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 12 1912   |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Talbot MD.                             |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Easton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Easton Memorial Hospital |  |   |                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>ELECTRIC WESTERN |   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Talbot  |   | 13c. CITY OR TOWN<br>Tilghman |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>21671<br>Tilghman Island Beach |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert E. Bartholomaei           |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katie L. Engelhardt   |   |                               |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-03-2879 |   |                               | 17. INFORMANT<br>ADDRESS<br>Albert E. Dallam, Sr. Arbutus, Md.                 |   |   |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 hrs<br>36 hrs |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23, 1983, to 2/18, 1983, that (I) (we) lost<br>saw the deceased alive on 2/18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Wm H Wood J  |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/18/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wm H Wood   |  |  |  | 22e. ADDRESS<br>EASTON MD   |  |   |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>2-20-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Tilghman Methodist Tilghman |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Talbot Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Newnam Funeral Home    |  |                      |  | ADDRESS<br>Easton, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1983            |  |
|  |  |                      |  |   |  | REGISTRAR'S SIGNATURE<br>John J. Gough                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 5 4 8 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>William MILTON Dennis</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 17 83</b>   |  | 2b. HOUR<br><b>1 PM</b>  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 20, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Easton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hosp @ Easton</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARETAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JARBLON &amp; JARBLON</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>----- Rural</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>TALBOT</b>   |  | 13c. CITY OR TOWN<br><b>MC DANIEL</b>   |  | 13f. ZIP CODE<br><b>21647</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVE DENNIS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH JANE BARNETT</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>  |  | 17. INFORMANT ADDRESS<br><b>MAE CONWAY MCDANIEL, MARYLAND 21647</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIAC ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9/30, 19 81</b> , to <b>2/1, 19 83</b> , that (1) (we) last saw the deceased alive on <b>2/1, 19 83</b> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>WS BREMER</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/17/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WS BREMER</b>   |  |  |  | 22e. ADDRESS<br><b>03 E CHESTNUT ST ST MICHAELS MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 21, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>THOMAS MEMORIAL ST. MICHAELS TALBOT Md.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. GENERAL DIRECTOR NAME<br><b>Thomas E. Leonard St. Michaels Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1983</b>   |  |  |  |
| 24. REGISTRAR SIGNATURE<br><b>Joan J. Connel</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-2000.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 83 05483  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John F. Doyle</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-27-83</b>  |  | 2b. HOUR<br><b>10:18</b> AM  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 25, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Purchasing Agt</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bechtel Corp</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Talbot</b>  |  | 13c. CITY OR TOWN<br><b>St. Michaels</b>  |  | 13d. STREET ADDRESS<br><b>Riverview Terrace 21663</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Doyle</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie M. Reardon</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth M. Doyle, St. Michaels, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Disease</b><br><b>43779</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10yrs</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Aspiration Pneumonia</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aspiration Pneumonia</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> 19 <b>83</b> , to <b>2/27</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Wm Wood</b> MD   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/1/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm Wood</b>   |  |   |  | 22e. ADDRESS<br><b>EASTON MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar 2, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hawson &amp; Leonard St. Michaels</b>  |  |   |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>John J. Leonard</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 8 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                                   |   |   |  |  |  |  |
|---|--|--|--|---|-----------------------------------|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Howard G IBB Edinger                 |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 5, 83 |   |                                   | 2b. HOUR<br>5:49 A M  |   |  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 12, 1916  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNA.                         |  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TALBOT MD.                                |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>EASTON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AUTO SALESMAN |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AUTO    |  |  |  |
| 13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>TALBOT                            |   | 13c. CITY OR TOWN<br>ST. MICHAELS |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>HAMBLETON VILLAGE 21663 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER EARL EDINGER               |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EMILY LOVETT   |                                   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |  | 16b. SOCIAL SECURITY NO.<br>WW11   |  | 17. INFORMANT<br>ADDRESS<br>HAMBLETON VILLAGE   |                                   | M. CORRINE EDINGER  |   | ST. MICHAELS, MD.                            |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/83 to 2/5/83, that (I) (we) last saw the deceased alive on 2/5/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Wm H Wood  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>2/5/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wm H Wood   |  |  |  | 22e. ADDRESS<br>EASTON Md  |  |  |  |

|  |  |                           |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>FEB. 8, 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN MEMORIAL PARK |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>EASTON TALBOT MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Thurston E Leonard     |  |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1983                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                    |  |

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RIGHTS REPORT

TO THE SECRETARY OF THE INTERIOR

FROM THE BUREAU OF LAND MANAGEMENT

FOR THE YEAR 1900

IN RESPONSE TO THE ORDER OF THE SECRETARY OF THE INTERIOR

OF THE 10TH MARCH 1900

AND THE ORDER OF THE SECRETARY OF THE INTERIOR

OF THE 10TH MARCH 1900

AND THE ORDER OF THE SECRETARY OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |   |  |
|---|--|---|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John A Fountain</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 3 83 2b. HOUR 10:10 M   |   |   |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Negro</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 8-6-06   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.                                     |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.                      |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>EASTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Caroline</b> 13c. CITY OR TOWN <b>Ridgely</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET ADDRESS <b>River Rd. 21660</b>   |  |   |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Fountain</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marceline Matthews</b>   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>213-24-1157</b>   |  | 17. INFORMANT ADDRESS <b>Madeline P. Fountain Ridgely, Md.</b>   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 1539 IMMEDIATE CAUSE (a) <b>Liver failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic colon carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>   |  |   |  |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |   |  |
| 22b. SIGNATURE <b>James Gieske</b> DEGREE <b></b>   |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED <b>2/4/83</b>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Gieske, M.D.</b>   |  |   |  |  | 22e. ADDRESS <b>Easton, Md. 21601</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-8-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cokers Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro Caroline Md.</b>      |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>   |   |  |
| 24. FUNERAL HOME <b>Boulais Funeral Home</b>  |  |   |  |  | 25c. CITY OR TOWN <b>Greensboro, Md.</b>   |   |   |   |  |

MEDICAL CERTIFICATION



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Easton Memorial Hospital

Ms. Caroline Riddely



River Rd.

Marceline Matheson

Charles Bonfatti

313-34-1125 Labeling R. 70000010

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |  | REG. NO.   |  |
|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William L. Gardner</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-14-83</b>   |   |   | 2b. HOUR<br>MIN. <b>11:31 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2-23-11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                         |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                          |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Caroline</b>   |   | 13c. CITY OR TOWN<br><b>Greensboro</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Knife Box Road 21639</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William R. Gardner</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Kibler</b>  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-36-3395</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy Gardner Greensboro, Md.</b>   |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4279</b> IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2-14-83 2-14-83</b>  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-14-83</b> to <b>2-14-83</b> , and that (I) (we) last saw the deceased alive on <b>2-14-83</b> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Thomas Fauntleroy, M.D.</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  |  | 22c. DATE SIGNED<br><b>2-15-83</b>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas Fauntleroy, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>Easton, Md. 21601</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2-18-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greensboro, Md.</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Greensboro Caroline Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John E. Boula's</b>  |  |   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1983</b>   |   |   |  |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br><b>John E. Boula's</b>   |  |   |  |   | 27. REGISTRAR'S SIGNATURE<br><b>John E. Boula's</b>  |   |   |  |  |  |  |

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Ms. Caroline Greenwood

William R. Gardner

Greenboro Caroline W.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST Elizabeth MIDDLE Sewell LAST GIBSON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 10 83 |   |  | 2b. HOUR<br>430 P.M.  |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 17, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 2 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Queen Anne Co. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TALBOT MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>EASTON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>school teacher              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Queen Anne  |  | 13c. CITY OR TOWN<br>Stevensville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Sewell   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Fisher  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>219-36-7338   |  | 17 INFORMANT<br>John W. Gibson Sr.   |  |   |  | ADDRESS<br>Rt. #1 Box 3 Stevensville, Md. 21666   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) H A S C V P<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Hx - CUA Hx Adenocarcinoma Breast Lymphadenopathy  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1-2, 1983, to 2-10, 1983, that (we) last saw the deceased alive on 2-10-83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (and not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Terry Detrick   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Terry Detrick, M.D.  |  |  |  | 22e. ADDRESS<br>Easton, Maryland 21601  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2-15-83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Stevensville Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Stevensville Queen Anne Md.                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Helfenbein-Hubbard  |  |  |  | ADDRESS<br>Chester, Md. 21619   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Gair   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA</b>  |  | FIRST MIDDLE LAST <b>GIBSON</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 4 83</b>   |  | 2b. HOUR <b>12:00</b> <sup>P</sup> <sub>M</sub>   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 25 1882</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>EASTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE PINES</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>   |  | 13b. COUNTY <b>TALBOT</b>   |  | 13c. CITY OR TOWN <b>ROYAL OAK</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT ADDRESS <b>Bx 172</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASVD = cerebrovascular disease =</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>yes.</b>   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  | (b) <b>insufficiency + bilateral lower lobe pneumonia = respiratory failure</b>   |  | (c) <b>and anast</b>   |  | 2 weeks   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>none</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 21/83</b> to <b>2/4</b> 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased or <input type="checkbox"/> saw that in (my) <input type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Albert T. Dawkins</b>  |  | DEGREE <b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>2/7/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT T. DAWKINS JR. M.D.</b>  |  | 22e. ADDRESS <b>14 N. AUREORA ST</b>  |  | CITY OR TOWN <b>EASTON</b> COUNTY <b>TAL</b> STATE <b>MD</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>2/9/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Richards</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>EASTON TAL MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>ERIC L. Dashiell</b>  |  | ADDRESS <b>P.O. Box 606, Easton</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





310



DATE MOVED

1000 FEB 10 1983



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 8 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |                                 |  |
|--|--|---|--|---|--|---|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR                        |  |
| Sara Ellen Goodyear  |  | Sara E Ellen Goodyear   |  | 2   |  | 17/83   |  | 10 <sup>04</sup> AM             |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH  |  | MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |
|  |  |   |  | Aug. 10, 1906   |  | 76  |  |                                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                 |  |
| Md.  |  | U.S.A.  |  |   |  | Talbot Talbot Co. MD.   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                 |  |
| Easton   |  | Memorial Hospital   |  | housewife   |  |   |  |                                 |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |                                 |  |
| Md.  |  | Q.A. Co.  |  | Chester   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                 |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |  |                                 |  |
| Harvey   |  | Dunkel  |  | Rt#2 Box # 745-S Chester Md. 21619  |  |   |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |  |                                 |  |
| No   |  | 159-24-8343   |  | June Raith, RT2 Box# 745-S Chester, Md. 21619   |  |   |  |                                 |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

2503

IMMEDIATE CAUSE (a)

Renal failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Diabetic nephropathy

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerotic cardiovascular dis.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

Enterocutaneous fistulae, Status post colon resection

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
| NONE  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 3 19 83 to FEB 17 19 83, that (I) (we) lost<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| Jonathan O. Hummel  |  | M.D.   |  |  |  | 2/17/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |
| Jonathan Hummel M.D.  |  |  |  | Easton Memorial Hosp., Easton Md. 21601  |  |   |  |

MEDICAL CERTIFICATION

1

|  |  |           |  |                                    |  |                            |  |
|--|--|-----------|--|------------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION              |  |
| Burial                                       |  | 2-21-83   |  | East Harrisburg Cem.               |  | Harrisburg Dauphin Co. Pa. |  |
| 24 FUNERAL DIRECTOR                          |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  |                            |  |
| NAME Helfenbein-Hubbard Funeral Home         |  |           |  | 25b. REGISTRAR'S SIGNATURE         |  |                            |  |
| Helfenbein-Hubbard FH, Box 66B Chestertown   |  |           |  | FEB 22 1983 John J. Canick         |  |                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STANDARD PAPER CO.



2000-0011

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO.                                  |  |
|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 8305490                                    |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR |  |
| MARY Ethel HAYMAN   |  |  |  |  | February 22, 1983 6:20 AM                 |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                |
| Female  |  | White  |  | MONTH DAY YEAR   |   | 7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.  |
| Nov. 12, 1901   |  | 81 YRS.  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |
| Maryland  |  | USA  |  | TALBOT MD.   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| EASTON  |  | MEMORIAL   |  | Homemaker  |   |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |   | 21613  |
| Maryland  |  | Dorchester Cambridge   |  | Hudson Road  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |   |  |
| Thomas L. McMahon   |  |  | Isabelle Majors                            |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |   |  |
| No  |  | 216-16-7312  |  | Mrs. Virginia Ege Baltimore, Md. 21225   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) cardiovascular collapse   |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular accident   |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cardiovascular disease  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
|   |  | 19   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |
|   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 22 Feb 1983, to 22 Feb 1983, that (I) (we) lost  |  |  |  |  |   |  |
| saw the deceased alive on 22 Feb 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |
| 12. B. Sanchez  |  | MD   |  |  |   | 2-22-83  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |   |  |
| 12. B. Sanchez  |  | 322 Commerce Dr Easton   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |
| Burial  |  | 2/24/83  |  | Green Lawn Cemetery  |   | Cambridge, Dor. Md.  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |   |  |
| John T. Brown   |  | 700 Forest St. Cambridge, Md.  |  | MAR 2 1983 John J. Carver  |   |  |



February 22, 1964  
MARY HANNA  
1450 1/2  
TARAT  
Eaton  
Maryland  
Washington, D.C.

1450 1/2  
Washington, D.C.  
1450 1/2  
Washington, D.C.

1450 1/2  
Washington, D.C.  
1450 1/2  
Washington, D.C.

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Washington, D.C.

1450 1/2  
Washington, D.C.  
1450 1/2  
Washington, D.C.



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|---|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.   |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AARON G. HILL</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>February 8 1983 2:48 M</b> |   |  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 6, 1933</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greenwood, Del.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                           |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery Co.</b>           |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Caroline</b>   |   | 13c. CITY OR TOWN<br><b>Federalsburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Edge</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Hill</b>         |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Korean War</b>  |  | 17. INFORMANT<br><b>Betty A. Hill</b>   |  | ADDRESS<br><b>315 S. Main Street, Federalsburg, Md.</b>                             |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br><b>4940</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchitis - severe/diffuse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>chronic</b><br><b>years</b> |  |   |  |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cor. Pulmonale</b>   |  |   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 78</b> to <b>2/8 83</b> that (I) (we) lost<br>saw the deceased alive on <b>2/7 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>P. Gregg Rhodes</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |   |  | 22c. DATE SIGNED<br><b>2/8/83</b>                                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. GREGG RHODES MD</b>  |  |   |  |   | 22e. ADDRESS<br><b>400 Dutchman's Ln, Easton, Md 21601</b>                 |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 10, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Veterans Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hurlock, Dorchester, Md.</b>       |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Frampton-Hawkins</b>   |  |   |  |   | ADDRESS<br><b>Box 43 Federalsburg, Md.</b>                                 |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |

BP



TA/047

Security Co.

Technical

215 S. Main Street

Charleston

Caroline

Wayland

Hotel Hill

Water Works

Yes Norman War 215-12-3941 Betty A. Hill, 215 S. Main St., Charleston



Bureau (215-12-3941) Norman War, 215 S. Main St., Charleston, W. Va.

215 S. Main St., Charleston, W. Va. 25301

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 9 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |   |  |                                    |  |  |
|--|--|---|--|---|--|--|---|--|------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MABEL S HOUGH</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 27 83</b>                     |   |  | 2b. HOUR<br><b>1:55 P</b>  |   |  |                                    |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 24 1908</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>74</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.  |   |  |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Switchboard op. Telephone</b>                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                    |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   | 13a. STATE<br><b>Md.</b>   |   |  | 13b. COUNTY<br><b>Talbot</b>   |   |  | 13c. CITY OR TOWN<br><b>Easton</b> |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   | 13e. STREET ADDRESS<br><b>201 Federal St. 21601</b>                    |   |  |  |   |  |                                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph E. Sterner</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Markle</b> |  |   |  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>194-01-7140</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Nancy H. Obitz Oxford, Md.</b>          |  |   |  |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic lung cancer</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>diabetic ketoacidosis 2° to steroid Rx</b>   |  |   |  |   |  |  |   |  |                                    |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-27, 1983</b> to <b>2-27, 1983</b> , that (I) (we) last saw the deceased alive on <b>2-27, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |   |  |                                    |  |  |
| 22b. SIGNATURE<br><b>R.B. Sanchez</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-1-83</b>  |                                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R.B. Sanchez</b>   |  |   | 22e. ADDRESS<br><b>322 Commerce Dr Easton MD</b>                       |   |  |  |   |  |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3-3-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Newton Cem.</b>          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>West Newton Land PA.</b> |  |                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnams Funeral Home</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>3 1983</b>                         |  |   |  |                                    |  |  |
| ADDRESS<br><b>Easton, Md. 21601</b>  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Conish</b>                    |  |   |  |                                    |  |  |





MAILED 2 NOV 1963  
U.S. DEPT. OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20240

TO: DIRECTOR, BLM  
FROM: SAC, [illegible]  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]

DATE: [illegible]  
BY: [illegible]  
[illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 9 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |   |
|---|--|--|--|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTIN MATTHEW Hubbard</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-2-83</b>                     |   |  | 2b. HOUR <b>1</b> AM   |  |  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 3, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER HUBBARD'S APPAREL</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>TALBOT</b>   |  | 13c. CITY OR TOWN<br><b>ST. MICHAEL'S</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 13e. STREET ADDRESS<br><b>404 WATER ST. 21663</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT HUBBARD</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK.</b> |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-32-0444</b>   |  | 17. INFORMANT<br><b>RUTH E. HUBBARD</b> ADDRESS <b>WATER ST. ST. MICHAELS, Md. 21663</b>  |  |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE, Post Necrotic Cirrhosis</b><br><b>5751</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Acute Cholelithiasis</b>   |  |  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>1-10-83</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CHOLECYSTITIS</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31, 1982</b> to <b>2-2, 1983</b> , that (I) (we) last saw the deceased alive on <b>2-1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Stephen P. Carney</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>2-2-83</b>  |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen P. Carney, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Easton, Md. 21601</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>FEB. 4, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLIVET CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ST. MICHAELS TALBOT Md.</b> |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harmon E. Leonard</b> ADDRESS<br><b>St. Michaels, Md.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 14 1983</b> <b>John J. Carney</b> |  |  |   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of or retained by the hospital or attending physician.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 05494

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Clifton H Johnson</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 27 1983</b>                                      |   | 2b. HOUR<br><b>6:40 AM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 5 1905</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>77</b> YRS.                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Talbot</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>R.R.</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |   |  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Talbot</b>  | 13c. CITY OR TOWN<br><b>EASTON</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>36 Locust St.</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Johnson</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgie Johnson</b>                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>715-14-9809</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Martha Young 36 Locust St. Md.</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitus</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> 19 <b>83</b> , to <b>2/27</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2/26</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>WM H WOOD</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/27/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WM H WOOD</b>   |   | 22e. ADDRESS<br><b>REASTON, MD</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>3/5/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RICHARDS MEM</b>                                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>EASTON Talbot Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eric L. Doherty</b>  |   | ADDRESS<br><b>P.O. Box 606 Easton Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>2 1983</b>                                |  |
| REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |   |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4-9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Fannie M. Johnson</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-15-83</b>   |   | 2b. HOUR<br><b>7<sup>35</sup> PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT 15 1921</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Store</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Talbot</b>  | 13c. CITY OR TOWN<br><b>Bozman</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Cooper Point Road 21612</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Albert Lavery</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tina Marie Folker</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-18-6069</b>  | 17. INFORMANT<br>ADDRESS<br><b>James Albert Lavery Bozman, Md 21612</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>2041</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC LYMPHOBLASTIC LEUKEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 day</b><br><b>9 yrs</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 Sep 1982</b> to <b>15 Feb 1983</b> , that (I) (we) last saw the deceased alive on <b>15 Feb 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                       |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Stephen P. Carney</b>   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-16-83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen P. Carney, M.D.</b>  |   |   | 22e. ADDRESS<br><b>Easton, Md. 21601</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-18-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill</b>  | 23d. LOCATION<br>CITY OR TOWN<br><b>Easton Talbot Md</b>   | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1983</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnam Funeral Home</b>   |   |   | 25. REGISTRAR'S SIGNATURE<br><b>John J. Carney</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

8-12-33 M. J. [illegible]

Trial

litigant [illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 9 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                                     |   |  |  |                                      |  |
|---|--|---|---|---|-------------------------------------|---|--|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY T. JONES, SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>FEB 3 1983</b> |   |                                     | 2b. HOUR<br><b>7<sup>35</sup></b>   |  |  |                                      |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 30, 1913</b>   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Preston, Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                           |  |  |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |   |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery Co.</b> |                                      |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Dorchester</b>                      |   | 13c. CITY OR TOWN<br><b>Hurlock</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 61</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Jones</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Williamson</b>   |                                     |   |  |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b> |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-3851A</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Margaret Jones, Box 61, Hurlock, Md. 21643</b>   |                                     |   |  |  |                                      |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>obstructing carcinoma of the colon - indefinite</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one week</b> |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>DIABETES MELLITUS; Renal failure</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/2</b> 19 <b>83</b> to <b>2/3</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>saw the deceased arrive on gurney (I) (we) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William J. Supul</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                     |  | 23b. DATE<br><b>Feb. 7, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Unity Washington Cem.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hurlock, Dorchester, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Frankton-Hurlock Federalburg Md</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR & REGISTRAR'S SIGNATURE<br><b>FEB 8 1983 John J. Smith</b> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 5 4 9 7  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Georgie A. Kendrick   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 22 1983   |  | 2b. HOUR<br>9:00P <sub>M</sub>   |   |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10-22-1906   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Talbot MD.  |   |
| 10 CITY OR TOWN OF DEATH<br>Easton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Meridian Nursing Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Virginia   |  |   |  | 13b. CITY OR TOWN<br>Fairfax   |  | 13c. STREET ADDRESS<br>6001 Arlington, Blvd.   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John M. Gott   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Bowen   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>224-62-3399   |  | 17 INFORMANT ADDRESS<br>Elizabeth Fryer Fort Washington, Md. 20744   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>4140 IMMEDIATE CAUSE (a) <i>Ischemic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Chronic Brain Syndrome. Bronchopneumonia.</i>  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 9, 1980</i> , to <i>Feb 22, 1983</i> , that (I) (we) last saw the deceased alive on <i>June 31, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><i>Richard F. Manegold MD</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>2-23-83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard F. Manegold, M.D.  |  |   |  | 22e. ADDRESS<br>Easton, Md.  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2-25-1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Waters Mem. Meth Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St. Leonard Calvert Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Donald V. Borgwardt   |  |   |  | ADDRESS<br>Port Republic, Md. 20676  |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 28 1983   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8 3 0 5 4 9 8   |   |  |   |  |
|--|--|---|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Walter Linwood Kinnamon</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-11-83</b>   |   |  | 2b. HOUR<br><b>8:28</b> <sup>A</sup> <sub>M</sub> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 26 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Tatbot</b> MD.                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital at Easton</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Caroline</b>  |  | 13c. CITY OR TOWN<br><b>Greensboro</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Rt. Box 270 21639</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter H. Kinnamon</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Annie Ross</b>   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-01-3193</b>  |  | 17. INFORMANT<br><b>Sallie Sculley Goldsboro, MD 21636</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ischemic heart disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>James Gieske</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Gieske, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>Easton, Md. 21601</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ridgely</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ridgely CA MD</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John E. Boula's Greensboro</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1983</b>   |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John E. Boula's</b>   |  |   |  |   |   |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP \_\_\_\_\_

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 4 9 9

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH H. KIRBY</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 2 14 83</b>  |  | 2b. HOUR<br><b>9<sup>05</sup> A.M.</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 3 1914</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                                       |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>EASTON MEMORIAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ser. Manager</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto dealer</b>                              |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Talbot</b> 13c. CITY OR TOWN <b>Easton</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>RD 2, Box 134 21601</b>                                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adolf Kirby</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie R. Radcliffe</b>                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   | 16b. SOCIAL SECURITY NO.<br><b>215-09-6973</b>  | 17. INFORMANT ADDRESS<br><b>Rosalie D. Kirby Easton, Md.</b>                                    |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BILATERAL SUBDURAL HEMATOMAS</b><br><b>4321</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 Days</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>AS HD 5 ventricles last seen</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1973</b> , 19 <b>2-14</b> to <b>2-14</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2-14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Stephen P. Carney</b>   |   | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>2-15-83</b>   |   |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br><b>Stephen P. Carney, M.D.</b>   |   | 22e. ADDRESS<br><b>Easton, Md. 21601</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-17-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Memorial</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Md</b>                           |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnam Funeral Home</b>   |   | ADDRESS<br><b>Easton, Md. 21601</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1983</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carney</b>   |

MEDICAL CERTIFICATION

29

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

103

James Earl Ray

James Earl Ray

James Earl Ray

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. THE 24 HOURS DEADLINE FOR FILING THIS CERTIFICATE WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  | REG. NO. 05500  |  |   |  |   |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Leis Kimberly Kirby</b>   |  |                         |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR <b>2 2 1983</b>              |  |   |  | 17. HOUR  |  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8-12-60</b>   |  | 6. AGE (IN YEARS)<br>LAST (TH) DAY YRS. <b>22</b>                      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 2 1983</b>                        |  | 18. HOUR  |  |   |  |
| 7a. BIRTHPLACE (STATE OR COUNTY)<br><b>Easton, MD</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b>                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hosp.</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bartender</b> |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bar</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY<br><b>Kent</b>  |  | 13c. CITY OR TOWN<br><b>Chestertown</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>Mill St. Chestertown</b>                                |  |   |  | 24620   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter J. Kirby</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Peggy Strother</b> |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-84-3150</b>  |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Walter Kirby -father- Chestertown</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br><b>8160</b> IMMEDIATE CAUSE (a) <b>Fractured Neck</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Auto Accident</b>  |  |                         |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/><br><b>21a PM 2 2 1983</b>  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Drove off road and struck tree</b>                                      |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, MARA, ETC.)<br><b>Highway</b>   |  |  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Talbot Co. MD</b>  |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                         |  |   |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>R. Lane Wroth</b>   |  |                         |  | M.D.<br><b>Talbot Street</b>  |  |  |  | MEDICAL EXAMINER<br><b>St. Michaels, Md. 21663</b>  |  |   |  | DATE SIGNED<br><b>2-3-83</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>R. Lane Wroth, M.D.</b>  |  |                         |  | ADDRESS<br><b>St. Michaels, Md. 21663</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |                         |  | 23b. DATE<br><b>2-5-83</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Berryville, Clarke VA</b>          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Edw. Fellows and Son Millington, MD 2165</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1983</b>                    |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                               |  |   |  |   |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |   |  | REG. NO. 83 05501                                      |  |  |
|--|--|---|---|---|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |   | 2b. HOUR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>GEORGE KOLPACK</u>   |  |   |   |   | 2a. DATE OF DEATH  |  | 2 MONTH 10 DAY 83   |   | 2b. HOUR 3 <sup>12</sup> P.M.  |  |  |  |
| 3. SEX <u>male</u>   |  | 4. RACE <u>white</u>                    |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>unknown</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 89 YRS.  |   | MONTHS DAYS   |  | HOURS MIN.   |  |  |
| 10. CITY OR TOWN OF DEATH <u>EASTON</u>  |  |   |   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>EASTON MEMORIAL HOSP.</u>        |  |   |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>TALBOT</u> MD. |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Police &amp; Food Store Manager</u>   |  |   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |  |  |  |  |
| 13a. STATE <u>Md.</u>  |  |   |   |   | 13b. COUNTY <u>Queen Annes</u>   |  | 13c. CITY OR TOWN <u>Stevensville</u>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <u>Stevensville, Md. 21666</u> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>unknown</u>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>unknown</u>  |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u>   |  |   |   |   | 16b. SOCIAL SECURITY NO. <u>218-16-5116</u>  |  | 17. INFORMANT ADDRESS <u>Mrs. Olive Lowe Rt. #3 Box 121 Stevensville, Md. 21666</u> |   |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><u>4140</u> IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Dis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u><br><u>years</u>   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Ex ribs &amp; Hydrothorax - (acute)</u>   |  |   |   |   |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>83</u> , to <u>2/10</u> , 19 <u>83</u> , that (I) (ye) last saw the deceased alive on <u>2/10</u> , 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (don) (did not) view the body after death.                          |  |   |   |   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE <u>P. Gregg Ruedes</u> DEGREE <u>MD</u>   |  |   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   |  | 22c. DATE SIGNED <u>2/19/83</u>                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. GREGG Ruedes MD</u>  |  |   |   |   | 22e. ADDRESS <u>400 Dutchmans Ln, Easton, Md 21601</u>   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |   | 23b. DATE <u>2-14-83</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Stevensville Queen Anne Co. Md.</u>  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Helpfenbein-Hubbard Funeral Home</u> ADDRESS <u>Chester, Md.</u>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR <u>FEB 22 1983</u>   |  |   | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>  |  |  |  |  |

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*[Faint, illegible handwriting and bleed-through from the reverse side of the page are visible throughout the document.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8 3 0 5 5 0 2  |     |                            |          |
|---|--|--|--|--|--|---|--|--|--|--|-----|----------------------------|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |     |                            |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR                       | 2b. HOUR |
| JEFFREY   |  |  |  |  |  | KRIEGER   |  | 2  |  | 15   | 83  | 12                         | M        |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |     |                            |          |
| Male  |  | White  |  | 8 MONTH 2 DAY 1969   |  | 13 YRS.   |  | MONTHS   |  | DAYS   |     | HOURS MIN.                 |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |     | MD.                        |          |
| Maryland  |  | USA  |  |  |  | TALBOT  |  |  |  |  |     |                            |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |     |                            |          |
| EASTON  |  | MEMORIAL HOSP. @ EASTON  |  | child  |  |   |  |  |  |  |     |                            |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |     | 21632                      |          |
| Maryland  |  | Caroline   |  | Fed. 21632   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 153 Idlewild Rd. Fed. Md.                                      |  |  |     |                            |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |     |                            |          |
| Irvin   |  | Kreiger, Jr. Mary  |  | Jane Tucker  |  |   |  |  |  |  |     |                            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |     | 21632                      |          |
| No  |  | 215-88-1800  |  | Irvin Kreiger  |  | 153 Idlewild Rd. Fed.   |  |  |  |  |     |                            |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |     |                            |          |
| 3489 IMMEDIATE CAUSE (a) Aspiration pneumonia   |  |  |  |  |  |   |  |  |  | 4 hours  |     |                            |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| (b) Severely brain damaged  |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| (c)   |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |     |                            |          |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |     |                            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NO; IF MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |     |                            |          |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |     |                            |          |
|   |  | P.M. 19  |  |  |  |   |  |  |  |  |     |                            |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |     |                            |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 19 83, that (I) (we) lost saw the deceased alive on 2-15-19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did); (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |     |                            |          |
| 22b. SIGNATURE  |  |  |  |  |  |   |  |  |  | DEGREE   |     | 22c. DATE SIGNED           |          |
| n. Deraufhan MD   |  |  |  |  |  |   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |     |                            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  | 22e. ADDRESS   |     |                            |          |
| M. DERAKSHANI   |  |  |  |  |  |   |  |  |  | Rt 3 Box 105A Easton Md  |     | 21601                      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY   |     | STATE                      |          |
| Burial  |  | 2-17-83  |  | Hillcrest  |  | Federalsburg Car. Md.   |  |  |  |  |     |                            |          |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |     | REGISTRAR'S SIGNATURE      |          |
| X Shaver Williams   |  |  |  |  |  |   |  |  |  | 21632  |     | FEB 22 1983 John J. Conner |          |
| FEDERALSBURG, MD.   |  |  |  |  |  |   |  |  |  |  |     |                            |          |

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FEU 110751

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |  |
|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Isaac Lewis</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-8-83</b> |  | 2b. HOUR <b>14</b><br>P.M.   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 10 28</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Fla.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>md.</b>   |   |   | 13b. COUNTY<br><b>Dorchester</b>                  | 13c. CITY OR TOWN<br><b>Rhodesdale</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET ADDRESS<br><b>Rural 21659</b>    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Lewis</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cleanor Lewis</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>263-42-5043</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Catherine Lewis Rt #1 Rhodesdale</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Mesothelioma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 6</b> , 19 <b>83</b> , to <b>Feb 8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Feb 8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard Manegold</b>  |   | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/9/83</b>            |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Manegold, M.D.</b>   |   | 22f. ADDRESS<br><b>Easton, Md. 21601</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-15-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cokesbury</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cokesbury Dorchester Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Perry &amp; Reese</b>   |   | ADDRESS<br><b>North St. Milford, Del.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>2-23-83</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |                                     |   | 8 3 0 5 5 0 4  |  |  |                                     |
|---|---|---|-------------------------------------|---|--|--|--|-------------------------------------|
| 1. FOR STATE REGISTRAR  |   |   |                                     |   | REG. NO.   |  |  |                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LAWRENCE O. LOCKNER</b>  |   |   |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 22 83</b>                                |  |  | 2b. HOUR<br>MIN.<br><b>6 50 P M</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cau.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-26-16</b>  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>66</b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>66</b>  |                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                                       |  |  |  |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Boiler</b>                                   |  |  |                                     |
| 13a. STATE<br><b>Md.</b>  |   | 13b. CITY OR TOWN<br><b>Caroline</b>  | 13c. CITY OR TOWN<br><b>Ridgely</b> | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>Rt 312</b>   |  | 21660  |                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Aquilla Lockner</b>  |   |   |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda McCullough</b>                       |  |  |  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-7009</b>  |                                     | 17. INFORMANT<br><b>Lydia Lockner</b>   |  | ADDRESS<br><b>Ridgely, Md.</b>   |  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma (Adeno) of Lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>with multiple metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b> |   |   |                                     |   |  |  |  |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic Heart Disease</b>  |   |   |                                     |   |  |  |  |                                     |
| 19a. DATE OF OPERATION<br><b>Jan 82</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Lung</b>  |                                     |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                     | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2169</b>                                |  |  |  |                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 22 1983</b> to <b>Feb 22 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 22 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |                                     |   |  |  |  |                                     |
| 23a. SIGNATURE<br><b>PGREGG RHODES, MD.</b>   |   |   |                                     | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/22/83</b>  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   |                                     | 22e. ADDRESS<br><b>400 Dutchman's Ln, Easton, Md</b>  |  |  |  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2-26-83</b>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ridgely Cemetery</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ridgely Caroline Md.</b>  |  |                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Boulais Funeral Home</b>   |   |   |                                     | ADDRESS<br><b>Greensboro, Md. 21639</b>   |  | DATE REC'D BY REGISTRAR<br><b>FEB 28 1983</b>  |  |                                     |

BP





Name

Can.

2-25-16

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U.S.A.

Mr.

Mr. Caroline Ridgely

Ridgely

x

Re 312

Angela Lockner

Angela Lockner

no

213-27-7009 Lydia Lockner

Ridgely, Mr.

FILED

2000

Mr.

2-25-83

Ridgely Cemetery

Ridgely Caroline Mr.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 0 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Blanche V. MARINE</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-4-83</b>                            |   |   | 2b. HOUR <b>5 A.M.</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>OCT. 29, 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Represent. Avon</b>                                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cosmetics</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Caroline</b>  |   | 13c. CITY OR TOWN<br><b>Preston</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>R. Elmer Bowdle</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Mae LeGates</b> |   |   | 16. STREET ADDRESS<br><b>R.D. 1, Box 153 X 21655</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-48-6958</b>  |   | 17. INFORMANT<br><b>Robert L. Willoughby Powhatan, VA.</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Acute Myocardial Infarction</b><br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASHD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASHD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>yes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/3</b> , 19 <b>83</b> , to <b>2/4</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Wm H Wood Jr MD</b>  |  |   | 22c. DEGREE<br><b>MD</b>  |   |   | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22e. DATE SIGNED<br><b>2/4/83</b>  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Wood Jr. M.D.</b>   |  |   | 22g. ADDRESS<br><b>Easton, Md</b>   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>2-6-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jr. Order Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Preston Caroline Md</b>                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnams Funeral Home</b>   |  |   | ADDRESS<br><b>Easton, MD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1983</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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NOTICE OF PROCEEDINGS

IN RE

RECEIVED

OFFICE OF THE CLERK

FILED

CLERK

OFFICE OF THE CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 0 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rufus M Mc Craw</b>                     |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-7-83</b> |   |  | 2b. HOUR<br><b>1 PM</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-17-21</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital at Easton</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WOOD MILL</b>         |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>Q.A.</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>BOX 19</b>   |  | 13e. <b>21651</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN McCRAW</b>                   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>LUCY JOHNSON</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>240-22-0302</b>  |   | 17. INFORMANT ADDRESS<br><b>FLORENCE McCRAW (WIFE) -SAME-</b>   |  |  |  |   |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

1629 IMMEDIATE CAUSE (a) **Bronchogenic Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**year**

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 6</b> 19 <b>82</b> , to <b>47</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Phlegg Rhodes MD</b>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>2/8/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PGREGG R. RODES M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>400 Ditchman's Lane, Easton, Md. 21601</b>                  |  |  |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-10-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRUMPTON CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CRUMPTON, Q.A., MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Edward Fellows &amp; Son</b> |  |                             |  | ADDRESS<br><b>Millington, Md.</b>                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1983</b>                     |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lister</b>        |  |   |  |



CHIEF

1011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 83 05507   |   |                 |  |
|---|--|---|--|--|--|--|--|--|--|---|---|-----------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Walter Morris  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22 1983   |   | 2b. HOUR 2:25pM |  |
| 3. SEX Male   |  | 4. RACE Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR NOV 25 1925  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.                                |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7b. HOUR HRS MIN.   |   |                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD                         |  |  |  |   |   |                 |  |
| 10. CITY OR TOWN OF DEATH Cordova   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) R.D. 1, Box 29 A |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman |  | 12b. KIND OF BUSINESS OR INDUSTRY Equip. Processing  |  |   |   |                 |  |
| 13a. STATE Md.  |  |   |  | 13b. COUNTY Talbot   |  | 13c. CITY OR TOWN Cordova  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS R.D. 1, Box 29 A 21625  |   |                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter D. Morris  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Lank   |  |  |  |  |  |   |   |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes   |  |   |  | 16b. SOCIAL SECURITY NO. 1943-1946   |  | 17. INFORMANT ADDRESS Katherine A. Morris Cordova, Md. 21625           |  |  |  |   |   |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 mos  |   |                 |  |
| 1579  |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Alcoholism   |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |   |                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 1983, to 2/22 83, that (I) (we) last saw the deceased alive on 2/8 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death. |  |   |  |  |  |  |  |  |  |   |   |                 |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED 2/24/83   |  |   |   |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald T. Lewers, M.D.  |  |   |  | 22e. ADDRESS Easton, Md.   |  |  |  |  |  |   |   |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |   |  | 23b. DATE 2-25-83  |  | 23c. NAME OF CEMETERY OR CREMATORY Fairview                            |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Cordova Talbot Md   |   |                 |  |
| 24. FUNERAL DIRECTOR NAME Newnam Funeral Home   |  |   |  |  |  | ADDRESS Easton, Md.  |  |  | 25a. DATE REC'D BY REGISTRAR FEB 28 1983 |   | 25b. REGISTRAR'S SIGNATURE John J. Carver |                 |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 0 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |   |   |   |                                 |
|--|--|---|---|--|--|---|---|---|---------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William E MURRAY</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 10 1983</b>            |  |  | 2b. HOUR <b>6:15 AM</b>   |   |   |                                 |
| 3. SEX <b>M</b>  |  | 4. RACE <b>Blk</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.                                    |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.                            |   |   |                                 |
| 10. CITY OR TOWN OF DEATH <b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>   |                                 |
| 13a. STATE <b>md</b>   |  | 13b. COUNTY <b>Talbot</b>   |   | 13c. CITY OR TOWN <b>Bellevue</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>Box 78 - Royal Oak</b>   |                                 |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>— — —</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>E. H. a</b>  |  |   |   |   |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-09-4652</b>   |   | 17. INFORMANT <b>MURRAY</b>  |  | ADDRESS <b>MURRAY</b>   |   |   |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal Bleeding</b><br><b>5850</b><br>DUE TO, OR AS A CONSEQUENCE OF -<br>(b) <b>Chronic Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Senile Dementia</b> |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b><br><b>1 yr</b>  |                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>Senile Dementia</b>   |  |   |   |  |  |   |   |   |                                 |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/9 1983</b>        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |   |   |                                 |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> 19 <b>83</b> , to <b>2/10</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2/9</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |   |   |   |                                 |
| 22b. SIGNATURE <b>Wm H Wood</b>  |  |   |   |  | DEGREE <b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>2/12/83</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WM H Wood</b>   |  |   |   |  | 22e. ADDRESS <b>EASTON Md.</b>   |   |   |   |                                 |
| 23a. BURIAL, CREMATION, REMOVAL <b>crem</b>  |  |   | 23b. DATE <b>2/14/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Richardson</b>                           |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot md</b>   |   |                                 |
| 24. FUNERAL DIRECTOR NAME <b>George Dashiell</b>   |  |   |   |  | ADDRESS <b>Easton, Md. 21601</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1983</b>  |   |                                 |
|  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>                               |   |   |   |                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8305509

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LULA <del>ROSS</del> ROSS</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 2 83</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 2b. HOUR<br><b>12 P M</b>  |  |
| 4. RACE<br><b>B/K</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 20 31</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>EASTON MEMORIAL HOSP.</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dramatic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>MD</b>   |  | 13b. CITY OR TOWN<br><b>Talbot</b>   |  |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>21601 Route #4 Box 635</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Mc Carter</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Madie Garrison</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Louise</b>   |  | ADDRESS<br><b>Ross</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST - ? Pul. EMBOLUS?</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS due to MASSIVE ULCER RT. OF CALCIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MIN</b><br><b>? 2 Mo -</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>SEVERE ANEMIA + NEPHROTIC SYNDROME</b>  |  |  |  |
| 19a. DATE OF OPERATION<br>_____  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost above, the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><b>John Knud-Hansen, M.D.</b>  |  | DEGREE   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22d. ADDRESS<br><b>Easton, Md. 21601</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE<br><b>2/6/83</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Corn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cambridge Port MD</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>John Knud-Hansen, M.D.</b>  |  | 25a. DATE REC'D. BY REGISTRAR (S. REGISTRAR'S SIGNATURE)<br><b>FEB 16 1983</b>   |  |

BP

TO: *101st Airborne Division*  
FROM: *101st Airborne Division*  
SUBJECT: *101st Airborne Division*  
1. *101st Airborne Division*  
2. *101st Airborne Division*  
3. *101st Airborne Division*  
4. *101st Airborne Division*  
5. *101st Airborne Division*  
6. *101st Airborne Division*  
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10. *101st Airborne Division*

11. *101st Airborne Division*  
12. *101st Airborne Division*  
13. *101st Airborne Division*  
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30. *101st Airborne Division*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 11 per phone 2/17/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR *Sheerin*

REG. NO. 8305510

|   |  |  |  |   |  |  |   |   |  |  |
|---|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Marilla A. Sheerin</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 3 1983</b>                   |   |  | 2b. HOUR<br><b>M</b>   |   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 26 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Dakota</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot County</b> MD.                     |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>At home</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Talbot</b>   |   | 13c. CITY OR TOWN<br><b>Easton</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>Route 50</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Cassian Andrews</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Alice Ingalls</b> |   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>4029</b>                                  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Stella George Easton, Md.</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Disease &amp; related stroke</b>                        |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>Yrs</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> 19 <b>81</b> to <b>2/3</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>2/26</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE <b>WM Wood Jr</b> DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |   | 22c. DATE SIGNED<br><b>2/7/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WM A Wood Jr</b>  |  |  |  | 22e. ADDRESS<br><b>EASTON, Md</b>   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 5</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholic Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN<br><b>Denton</b>  |   | COUNTY<br><b>Caroline</b> STATE<br><b>Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Edna Williams</b>   |  |  |  | ADDRESS<br><b>Federalburg</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1983</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>   |  |  |



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South Boston . . . x

House No. 1045

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8305511   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Simon   |  |  |  | 2b. HOUR 7:55A.M.  |  |   |  |
| 3. SEX Male  |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.   |  |
| 7. BIRTHPLACE (COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.   |  |
| 10. CITY OR TOWN OF DEATH Easton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY Transport-  |  |
| 13a. STATE Maryland  |  | 13b. COUNTY Caroline   |  | 13c. CITY OR TOWN Ridgely  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Simons   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Kuhn  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 221072171  |  |
| 17. INFORMANT ADDRESS Mrs. Joann Mitton, Ridgely, Md.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic CA |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 1629   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from DECEMBER 19 82, to FEBRUARY 19 83, that (I) (we) saw the deceased alive on FEBRUARY 15 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE [Signature]   |  | DEGREE MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 2-18-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL D. CROWLEY   |  | 22e. ADDRESS 322 COMMERCE DR - EASTON MD 21601   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  | 23b. DATE 2/19/83  |  | 23c. NAME OF CEMETERY OR CREMATORY Cape Henlopen   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Delaware   |  |
| 24. FUNERAL DIRECTOR NAME RANDOLPH P. MOORE  |  | ADDRESS DENTON, Md.  |  | 25. DATE RECEIVED BY REGISTRAR FEB 24 1983   |  |   |  |



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 1 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CORA MAE SLAUGHTER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 13 83                         |   |  | 2b. HOUR<br>2 P M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 9 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TALBOT MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>EASTON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSP EASTON |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Country   |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY<br>Talbot  |   | 13c. CITY OR TOWN<br>Oxford                                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Greene   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marrietta Brooks      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-24-1594 |   | 17. INFORMANT<br>ADDRESS<br>Wm Slaughter Box 44A Oxford, MD. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute myocardial infarction<br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>(b) coronary artery disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) atherosclerotic cardiovascular disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>years<br>years |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>various cardiac arrhythmias + anemia   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>14 N. AURORA ST EASTON, MD   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Monday, 19 75, to 2/13, 19 83, that (I) (we) last saw the deceased alive on 4/13, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Albert T. Dawkins Jr.   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>2/13/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT T. DAWKINS JR. M.D.   |  |   |  | 22e. ADDRESS<br>14 N. AURORA ST EASTON, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/18/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Paradise  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Talbot MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Eric Aspruells  |  |   |  | ADDRESS<br>426 Dewey St   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1983   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



FEB 24 1963  
FBI - NEW YORK

RECEIVED

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 1 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR E STERLING</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 22 83</b>   |  | 2b. HOUR<br><b>5<sup>03</sup> PM</b>  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 1, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TALBOT</b> MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>EASTON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - -</b> |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Talbot</b>  | 13c. CITY OR TOWN<br><b>Easton</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur H. Edwards</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Dickinson</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>231-40-3373</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Thomas W. Sterling, Jr. Same as 13 a,b,c,d,e</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>months</b> |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>2-22-83</b> to <b>2-22-83</b> that (we) last saw the deceased alive on <b>2-22-83</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Thomas W. Fauntleroy, Jr. M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>2/25/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas W. Fauntleroy, Jr. M.D.</b>   |   | 22e. ADDRESS<br><b>139 S. Washington St. Easton, MD 21601</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/25/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury Cemetery</b>                                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crisfield Somerset Md.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1983</b>  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bradshaw &amp; Sons Crisfield, Md. 21817</b>  |   |   |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



# STANDARD

| STANDARD |     | STANDARD |      | STANDARD |      |
|----------|-----|----------|------|----------|------|
| 1        | 2   | 3        | 4    | 5        | 6    |
| 7        | 8   | 9        | 10   | 11       | 12   |
| 13       | 14  | 15       | 16   | 17       | 18   |
| 19       | 20  | 21       | 22   | 23       | 24   |
| 25       | 26  | 27       | 28   | 29       | 30   |
| 31       | 32  | 33       | 34   | 35       | 36   |
| 37       | 38  | 39       | 40   | 41       | 42   |
| 43       | 44  | 45       | 46   | 47       | 48   |
| 49       | 50  | 51       | 52   | 53       | 54   |
| 55       | 56  | 57       | 58   | 59       | 60   |
| 61       | 62  | 63       | 64   | 65       | 66   |
| 67       | 68  | 69       | 70   | 71       | 72   |
| 73       | 74  | 75       | 76   | 77       | 78   |
| 79       | 80  | 81       | 82   | 83       | 84   |
| 85       | 86  | 87       | 88   | 89       | 90   |
| 91       | 92  | 93       | 94   | 95       | 96   |
| 97       | 98  | 99       | 100  | 101      | 102  |
| 103      | 104 | 105      | 106  | 107      | 108  |
| 109      | 110 | 111      | 112  | 113      | 114  |
| 115      | 116 | 117      | 118  | 119      | 120  |
| 121      | 122 | 123      | 124  | 125      | 126  |
| 127      | 128 | 129      | 130  | 131      | 132  |
| 133      | 134 | 135      | 136  | 137      | 138  |
| 139      | 140 | 141      | 142  | 143      | 144  |
| 145      | 146 | 147      | 148  | 149      | 150  |
| 151      | 152 | 153      | 154  | 155      | 156  |
| 157      | 158 | 159      | 160  | 161      | 162  |
| 163      | 164 | 165      | 166  | 167      | 168  |
| 169      | 170 | 171      | 172  | 173      | 174  |
| 175      | 176 | 177      | 178  | 179      | 180  |
| 181      | 182 | 183      | 184  | 185      | 186  |
| 187      | 188 | 189      | 190  | 191      | 192  |
| 193      | 194 | 195      | 196  | 197      | 198  |
| 199      | 200 | 201      | 202  | 203      | 204  |
| 205      | 206 | 207      | 208  | 209      | 210  |
| 211      | 212 | 213      | 214  | 215      | 216  |
| 217      | 218 | 219      | 220  | 221      | 222  |
| 223      | 224 | 225      | 226  | 227      | 228  |
| 229      | 230 | 231      | 232  | 233      | 234  |
| 235      | 236 | 237      | 238  | 239      | 240  |
| 241      | 242 | 243      | 244  | 245      | 246  |
| 247      | 248 | 249      | 250  | 251      | 252  |
| 253      | 254 | 255      | 256  | 257      | 258  |
| 259      | 260 | 261      | 262  | 263      | 264  |
| 265      | 266 | 267      | 268  | 269      | 270  |
| 271      | 272 | 273      | 274  | 275      | 276  |
| 277      | 278 | 279      | 280  | 281      | 282  |
| 283      | 284 | 285      | 286  | 287      | 288  |
| 289      | 290 | 291      | 292  | 293      | 294  |
| 295      | 296 | 297      | 298  | 299      | 300  |
| 301      | 302 | 303      | 304  | 305      | 306  |
| 307      | 308 | 309      | 310  | 311      | 312  |
| 313      | 314 | 315      | 316  | 317      | 318  |
| 319      | 320 | 321      | 322  | 323      | 324  |
| 325      | 326 | 327      | 328  | 329      | 330  |
| 331      | 332 | 333      | 334  | 335      | 336  |
| 337      | 338 | 339      | 340  | 341      | 342  |
| 343      | 344 | 345      | 346  | 347      | 348  |
| 349      | 350 | 351      | 352  | 353      | 354  |
| 355      | 356 | 357      | 358  | 359      | 360  |
| 361      | 362 | 363      | 364  | 365      | 366  |
| 367      | 368 | 369      | 370  | 371      | 372  |
| 373      | 374 | 375      | 376  | 377      | 378  |
| 379      | 380 | 381      | 382  | 383      | 384  |
| 385      | 386 | 387      | 388  | 389      | 390  |
| 391      | 392 | 393      | 394  | 395      | 396  |
| 397      | 398 | 399      | 400  | 401      | 402  |
| 403      | 404 | 405      | 406  | 407      | 408  |
| 409      | 410 | 411      | 412  | 413      | 414  |
| 415      | 416 | 417      | 418  | 419      | 420  |
| 421      | 422 | 423      | 424  | 425      | 426  |
| 427      | 428 | 429      | 430  | 431      | 432  |
| 433      | 434 | 435      | 436  | 437      | 438  |
| 439      | 440 | 441      | 442  | 443      | 444  |
| 445      | 446 | 447      | 448  | 449      | 450  |
| 451      | 452 | 453      | 454  | 455      | 456  |
| 457      | 458 | 459      | 460  | 461      | 462  |
| 463      | 464 | 465      | 466  | 467      | 468  |
| 469      | 470 | 471      | 472  | 473      | 474  |
| 475      | 476 | 477      | 478  | 479      | 480  |
| 481      | 482 | 483      | 484  | 485      | 486  |
| 487      | 488 | 489      | 490  | 491      | 492  |
| 493      | 494 | 495      | 496  | 497      | 498  |
| 499      | 500 | 501      | 502  | 503      | 504  |
| 505      | 506 | 507      | 508  | 509      | 510  |
| 511      | 512 | 513      | 514  | 515      | 516  |
| 517      | 518 | 519      | 520  | 521      | 522  |
| 523      | 524 | 525      | 526  | 527      | 528  |
| 529      | 530 | 531      | 532  | 533      | 534  |
| 535      | 536 | 537      | 538  | 539      | 540  |
| 541      | 542 | 543      | 544  | 545      | 546  |
| 547      | 548 | 549      | 550  | 551      | 552  |
| 553      | 554 | 555      | 556  | 557      | 558  |
| 559      | 560 | 561      | 562  | 563      | 564  |
| 565      | 566 | 567      | 568  | 569      | 570  |
| 571      | 572 | 573      | 574  | 575      | 576  |
| 577      | 578 | 579      | 580  | 581      | 582  |
| 583      | 584 | 585      | 586  | 587      | 588  |
| 589      | 590 | 591      | 592  | 593      | 594  |
| 595      | 596 | 597      | 598  | 599      | 600  |
| 601      | 602 | 603      | 604  | 605      | 606  |
| 607      | 608 | 609      | 610  | 611      | 612  |
| 613      | 614 | 615      | 616  | 617      | 618  |
| 619      | 620 | 621      | 622  | 623      | 624  |
| 625      | 626 | 627      | 628  | 629      | 630  |
| 631      | 632 | 633      | 634  | 635      | 636  |
| 637      | 638 | 639      | 640  | 641      | 642  |
| 643      | 644 | 645      | 646  | 647      | 648  |
| 649      | 650 | 651      | 652  | 653      | 654  |
| 655      | 656 | 657      | 658  | 659      | 660  |
| 661      | 662 | 663      | 664  | 665      | 666  |
| 667      | 668 | 669      | 670  | 671      | 672  |
| 673      | 674 | 675      | 676  | 677      | 678  |
| 679      | 680 | 681      | 682  | 683      | 684  |
| 685      | 686 | 687      | 688  | 689      | 690  |
| 691      | 692 | 693      | 694  | 695      | 696  |
| 697      | 698 | 699      | 700  | 701      | 702  |
| 703      | 704 | 705      | 706  | 707      | 708  |
| 709      | 710 | 711      | 712  | 713      | 714  |
| 715      | 716 | 717      | 718  | 719      | 720  |
| 721      | 722 | 723      | 724  | 725      | 726  |
| 727      | 728 | 729      | 730  | 731      | 732  |
| 733      | 734 | 735      | 736  | 737      | 738  |
| 739      | 740 | 741      | 742  | 743      | 744  |
| 745      | 746 | 747      | 748  | 749      | 750  |
| 751      | 752 | 753      | 754  | 755      | 756  |
| 757      | 758 | 759      | 760  | 761      | 762  |
| 763      | 764 | 765      | 766  | 767      | 768  |
| 769      | 770 | 771      | 772  | 773      | 774  |
| 775      | 776 | 777      | 778  | 779      | 780  |
| 781      | 782 | 783      | 784  | 785      | 786  |
| 787      | 788 | 789      | 790  | 791      | 792  |
| 793      | 794 | 795      | 796  | 797      | 798  |
| 799      | 800 | 801      | 802  | 803      | 804  |
| 805      | 806 | 807      | 808  | 809      | 810  |
| 811      | 812 | 813      | 814  | 815      | 816  |
| 817      | 818 | 819      | 820  | 821      | 822  |
| 823      | 824 | 825      | 826  | 827      | 828  |
| 829      | 830 | 831      | 832  | 833      | 834  |
| 835      | 836 | 837      | 838  | 839      | 840  |
| 841      | 842 | 843      | 844  | 845      | 846  |
| 847      | 848 | 849      | 850  | 851      | 852  |
| 853      | 854 | 855      | 856  | 857      | 858  |
| 859      | 860 | 861      | 862  | 863      | 864  |
| 865      | 866 | 867      | 868  | 869      | 870  |
| 871      | 872 | 873      | 874  | 875      | 876  |
| 877      | 878 | 879      | 880  | 881      | 882  |
| 883      | 884 | 885      | 886  | 887      | 888  |
| 889      | 890 | 891      | 892  | 893      | 894  |
| 895      | 896 | 897      | 898  | 899      | 900  |
| 901      | 902 | 903      | 904  | 905      | 906  |
| 907      | 908 | 909      | 910  | 911      | 912  |
| 913      | 914 | 915      | 916  | 917      | 918  |
| 919      | 920 | 921      | 922  | 923      | 924  |
| 925      | 926 | 927      | 928  | 929      | 930  |
| 931      | 932 | 933      | 934  | 935      | 936  |
| 937      | 938 | 939      | 940  | 941      | 942  |
| 943      | 944 | 945      | 946  | 947      | 948  |
| 949      | 950 | 951      | 952  | 953      | 954  |
| 955      | 956 | 957      | 958  | 959      | 960  |
| 961      | 962 | 963      | 964  | 965      | 966  |
| 967      | 968 | 969      | 970  | 971      | 972  |
| 973      | 974 | 975      | 976  | 977      | 978  |
| 979      | 980 | 981      | 982  | 983      | 984  |
| 985      | 986 | 987      | 988  | 989      | 990  |
| 991      | 992 | 993      | 994  | 995      | 996  |
| 997      | 998 | 999      | 1000 | 1001     | 1002 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |   |   |   |  |  |  |                                   | 83 05514                                     |      |          |
|--|--|------------------------------|---|---|---|--|--|--|-----------------------------------|--|------|----------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.                     |   |   |   |  |  |  |                                   |  |      |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | FIRST   | MIDDLE  | LAST  | 2a. DATE OF DEATH  |  |  | MONTH                             | DAY  | YEAR | 2b. HOUR |
| MARY L Strickroth  |  |                              |   |   |   | 2-15-83  |  |  |                                   |  |      | 2:30 AM  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |      |          |
| Female   |  | caucasian                    |   | DEC. 25 1922  |   | 60   |  | MONTHS   |                                   | DAYS   |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |  |      |          |
| Maryland   |  | U.S.A.                       |   |   |   | TALBOT MD.   |  |  |                                   |  |      |          |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |      |          |
| EASTON   |  |                              | Memorial Hospital   |   |   | Housewife  |  |  |                                   |  |      |          |
| 13a. STATE   |  |                              | 13b. COUNTY   |   | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |                                   |  |      |          |
| Md.  |  |                              | Talbot  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | R.D. 3, Box 255 21601  |  |                                   |  |      |          |
| 14. FATHER'S NAME  |  |                              |   |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |                                   |  |      |          |
| H. Leslie Sparks   |  |                              |   |   | Sarah Lena Willey   |  |  |  |                                   |  |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |  |  |                                   |  |      |          |
| No   |  |                              | 220-14-1643   |   | John G. Strickroth Easton, Md.                                      |  |  |  |                                   |  |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                              |   |   |   |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |          |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4140 Congestive Heart failure</u>   |  |                              |   |   |   |  |  |  |                                   | 24 Uncertain                                 |      |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart disease</u>  |  |                              |   |   |   |  |  |  |                                   |  |      |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                              |   |   |   |  |  |  |                                   |  |      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Scleroderma</u>  |  |                              |   |   |   |  |  |  |                                   |  |      |          |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |      |          |
|  |  |                              |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                                   |  |      |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |  |      |          |
| 22a. I certify that (u) (this hospital) attended the deceased from <u>1-24</u> 19 <u>83</u> , to <u>2-15</u> 19 <u>83</u> , that (l) (we) saw the deceased alive on <u>2-15</u> 19 <u>83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (l) (we) (did) (did not) view the body after death. |  |                              |   |   |   |  |  |  |                                   |  |      |          |
| 22b. SIGNATURE<br>Robert W. Trever, M.D.   |  |                              |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2-15-83                                    |                                   |  |      |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert W. Trever, M.D.  |  |                              |   |   |   | 22e. ADDRESS<br>RD3 Box 297 Easton, Md. 21601  |  |  |                                   |  |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                              | 23b. DATE<br>2-18-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Spring Hill                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Easton Talbot Md |  |                                   |  |      |          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Newnam Funeral Home Easton, Md.  |  |                              |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 18 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Coniff                   |                                   |  |      |          |



May 1961

Total

100.00

100.00

100.00

100.00

100.00

100.00





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 1 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Adrianna P. Taylor</b>                              |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>83</b> |   |  | 2b. HOUR<br><b>3:55</b> P.M.  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>16</b> YEAR <b>1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |  | 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Caroline</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13d. STREET ADDRESS<br><b>Melville Road</b>  |  | 13e. STREET ADDRESS<br><b>21640</b>   |  | 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>   |  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>569-14-5198</b>  |  | 17. INFORMANT<br><b>Grace A. Cain</b> ADDRESS<br><b>Marydel, Md.</b>                            |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **5715 Negative Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Laennec's Cirrhosis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Esophageal Varices Bleeding**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**acute** **yrs.****acute**

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/17/83</b> to <b>2/17/83</b> , that (I) (we) last saw the deceased alive on <b>2/17/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>PGREGG RHODES</b> DEGREE <b>MD</b>  |  |  |  |  |  | 22c. DATE SIGNED<br><b>2/16/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PGREGG RHODES MD</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>400 Dutchman's Lane Easton, Md 21601</b>  |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> |  | 23b. DATE<br><b>2-18-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Delmarva Crematory</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lewes Sussex Del.</b> |  |
|--|--|-----------------------------|--|---|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME <b>Al. Boulais</b> ADDRESS <b>Greensboro MD</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b> |  |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

U.S. News & World Report

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1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 26

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEARLY PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |   |  |  |  |   |  |   |  | REG. NO. 05516   |  |  |  |  |  |  |  |
|---|--|------------------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert C. Thompson</b>   |  |                              |  |   |  |  |  |   |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br><b>7 7 1983</b>           |  | 2c. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 - 2 1983</b> |  |  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>       |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br><b>JUNE 6 1943</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>39</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |  | 2d. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>7 - 2 1983</b>                  |  | 2e. HOUR OF DEATH<br><b>7:30 PM</b>                      |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Talbot</b>                            |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Easton</b>  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Representative</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Liquor</b>                               |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Talbot</b> |  | 13c. CITY OR TOWN<br><b>Oxford</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>R.D. 1, Box 151</b>   |  |   |  | 21654  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John L. Thompson Jr.</b>  |  |                              |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ethel Colwell</b>                           |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                              |  | 16b. SOCIAL SECURITY NO.<br><b>214-42-8890</b>  |  | 17. INFORMANT ADDRESS<br><b>Shelia M. Thompson Oxford, Md</b>                                |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8120</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Crushed Left Chest</b><br>(c) <b>Crushed Chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                       |  |                              |  |   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                              |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>Driver of auto struck on left side</b>   |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>7:30 M. 7 7 1983</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver of auto struck on left side</b>                                  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Highway</b>   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Llandaff Rd + RD 333 Talbot Md.</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                              |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>R. Lane Wroth</b>  |  |                              |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |  |  | M.D.<br><b>Deputy</b>   |  |   |  | MEDICAL EXAMINER<br><b>Deputy</b>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>R. Lane Wroth, M.D.</b>   |  |                              |  | ADDRESS<br><b>St. Michaels, Md.</b>   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                              |  | 23b. DATE<br><b>2-10-83</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oxford Cemetery</b>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Oxford Talbot Md</b>               |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Newnam Funeral Home Easton, Md.</b>   |  |                              |  |   |  |  |  |   |  |   |  | 25. DATE REG'D BY REGISTRAR<br><b>FEB 9 1983</b>                                 |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |  |

MEDICAL CERTIFICATION

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4. 2

Handwritten signature: *James B. ...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>2/25/83 kam<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>OLIVIA BURNS TOMES  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB. 20, 1983                       |  |  | 2b. HOUR<br>8:30 P.M.  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT. 2, 1889   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92-93 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TALBOT MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>EASTON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERITAN - THE PINES |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. CITY OR TOWN<br>TALBOT   |  | 13c. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |   | 13e. STREET ADDRESS<br>WEST MAPLE ST. 21663  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES FLETCHER BURNS  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH OLIVIA HARRISON |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>184-10-8615   |  | 17. INFORMANT ADDRESS<br>DOROTHY B. GARDNER BOX 157<br>ST. MICHAELS, MARYLAND 21663   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(d) _____<br>(e) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Arteriosclerotic Cardiovascular Disease</i> |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 10</i> 19 <i>69</i> to <i>20 Feb</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>19 Feb</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE DEGREE<br><i>R. Lane Wroth, M.D.</i>  |  |   |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>2-21-83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. LANE WROTH M.D.  |  |   |  |   |   | 22e. ADDRESS<br>ST. MICHAELS, MARYLAND 21663   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b. DATE<br>FEB. 22, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FT. LINCOLN CEM. BRENTWOOD P.G. Md.   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Hanson &amp; C. Leonard St. Michaels, Md.</i>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

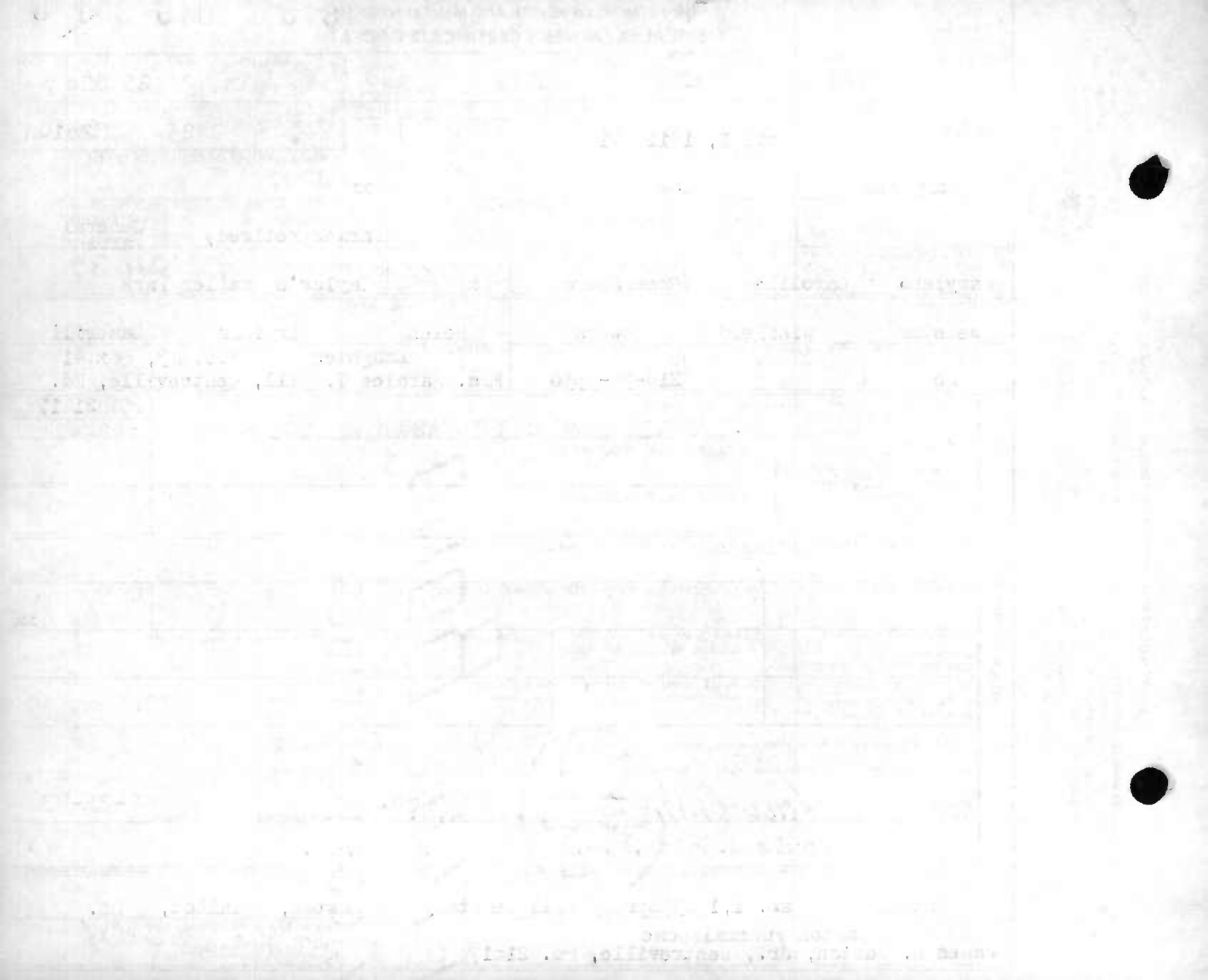
BP

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |  |  |  |  |  | REG. NO. 8 3 0 5 5 1 8   |  |  |  |
|--|--|--------------|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |              |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WILLIAM LEE TOWERS   |  |              |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>2 25 1982                    |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>W |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 2, 1911                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>71 YRS. |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>2 25 1982   |  | 7d. HOUR<br>10A  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                       |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>NR EASTON   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>AIRPORT MOTEL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer (retired)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>General Farming   |  |
| 13a. STATE<br>Maryland   |  |              |  |   |  |  |  |  |  | 13b. CITY OR TOWN<br>Caroline  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Webster Winfield Towers   |  |              |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Virginia Gambrill            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |
| 16b. SOCIAL SECURITY NO.<br>218-30-5550  |  |              |  |   |  |  |  |  |  | 17. INFORMANT<br>Daughter  |  | ADDRESS<br>R.D. #3, Box 41   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |              |  |   |  |  |  |  |  | APPROXIMATE AGE AT DEATH<br>24 1/2 years   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |              |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)               |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |  |   |  |  |  |  |  | TITLE (SPECIFY)<br>A.D.E.P.  |  | DATE SIGNED<br>2-25-83   |  |
| ACTUAL SIGNATURE<br>Louis S. Welty   |  |              |  | M.D.<br>Louis S. Welty, M.D.  |  |  |  | MEDICAL EXAMINER   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Louis S. Welty, M.D.  |  |              |  | ADDRESS<br>Easton, Md.  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |              |  | 23b. DATE<br>Mar. 1, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Spring Hill Cemetery       |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Easton, Talbot, Md.                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>James H. Barton, Jr., Centreville, Md. 21617  |  |              |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1983                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lawler   |  |  |  |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 83 05519  |  |  |  |
|--|--|---|--|---|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>1da M Turner  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-24-83 |   | 2b. HOUR<br>8:25 AM   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>B/K  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 9 10  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Talbot MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Easton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital at Easton                |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Talbot   |  | 13c. CITY OR TOWN<br>Bellevue   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Will Chester   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jennie ? Chester   |  | 13e. STREET ADDRESS<br>P.O. Box 89 21601  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>285-12-6439  |  | 17. INFORMANT<br>Kermit Turner  |   | ADDRESS  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>  |  |   |  |   |   |  |  |  |
| 1509 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASPIRATION PNEUMONIA</u>   |  |   |  |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>ESOPHAGEAL CARCINOMA WITH TRACHEO-ESOPHAGEAL FISTULA</u>  |  |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>83</u> , to <u>2/24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>WS Bremer  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br>2/24/83  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WS BREMER   |  | 22e. ADDRESS<br>103 E. CHESTNUT ST ST MICHAELS MD   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)   |  | 23b. DATE<br>2/28/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Thomas Corn   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St Michaels TA MD                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George H. Dashiell Funeral Home  |  | ADDRESS<br>Easton, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1983  |   |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lammie  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 5 5 2 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                             |   |   |  |   |                        |  |
|--|--|--|--|---|-----------------------------|---|---|--|---|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Pauline D. Walker   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 11 83 |   |                             | 2b. HOUR<br>2 <sup>4</sup> M  |   |  |   |                        |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 12 1891  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Talbot MD.                            |   |  |   |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Easton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |  |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |   |                        |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Talbot                            |   | 13c. CITY OR TOWN<br>Easton |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>36 S. Washington St. 21601 |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Dietert  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Thom  |                             |   |   |  |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-01-8201   |                             | 17. INFORMANT<br>Howard E. Walker   |   |  |   | ADDRESS<br>Easton, Md. |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Anasarca

4029

DUE TO, OR AS A CONSEQUENCE OF

(b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertensive and arteriosclerotic heart disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Lupus erythematosus, Angiodysplasia of stomach, GI bleeding, Carcinoma of breast, Myeloproliferative disease

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8-30, 1982, to 2-11, 1983, that (1) (we) last saw the deceased alive on 2-10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Robert W. Trever, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2-11-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert W. Trever, M.D.   |  |  |  | 22e. ADDRESS<br>RD3 Box 297 Easton, Md. 21601  |  |   |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>2-14-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Spring Hill |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Easton Talbot Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Newnam Funeral Home    |  |                      |  | ADDRESS<br>Easton, Md. 21601                      |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1983                   |  |
|  |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver      |  |  |  |

Position of the ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |  |  |  |  |   |
|--|--|--|---|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 8 3 0 5 5 2 1  |  |  |  |   |
| 1. DECEASED NAME   |  |  |   |   | 2a. DATE OF DEATH  |  |  |  |   |
| FIRST MIDDLE LAST  |  |  |   |   | MONTH DAY YEAR HOUR  |  |  |  |   |
| JESSIE Amos WEBB   |  |  |   |   | 2 9 83 10 <sup>57</sup> A M  |  |  |  |   |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                              |  | 7. IF UNDER 1 YEAR   |   |
| Male   |  | Black  |   | MONTH DAY YEAR  |  | 82   |  | MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                         |  |  |   |
| 35 Maryland  |  | USA  |   |   |  | TALBOT MD.   |  |  |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |
| 78 EASTON  |  | MEMORIAL HOSPITAL @ EASTON   |   |   |  | Self   |  |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS                                      |  |   |
| 35 MD.   |  |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 120 Port St. 21601                                       |  |   |
| 14. FATHER'S NAME  |  |  |   |   | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |
| 200 ENOCH MIDDLE LAST Webb   |  |  |   |   | Aiventa MIDDLE LAST Sharp  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |
| 1 No   |  |  |   |   | 214-34-7325  |  | Dale S Webb 102 Port Street EASTON, MD 21601             |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIAC ARREST   |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |   |   |  |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |   |  |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
|  |  |  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |
|  |  |  | P.M. 19   |   |  |  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |
|  |  |  |   |   |  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 2/9/83, 19, the (I) (we) lost saw the deceased alive on 2/9/83, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. |  |  |   |   |  |  |  |  |   |
| 22b. SIGNATURE C. W. BAIN MD   |  |  |   |   | DEGREE   |  |  | 22c. DATE SIGNED   |   |
|  |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 2-9-83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C R W BAIN   |  |  |   |   | 22e. ADDRESS Easton, Pa, 21601.  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |   |
| Burial   |  |  | 2/14/83   |   | Mt. Zion Church  |  | Bethelam, Caroline MD.                                   |  |   |
| 24. FUNERAL DIRECTOR NAME ERIC L. Dashirell  |  |  |   |   | ADDRESS P.O. Box 606, Easton, MD   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |   |
|  |  |  |   |   |  |  | FEB 10 1983 John J. Canish                               |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                                  |  |                  |  |
|---|--|---|--|---|--|---|--|----------------------------------|--|------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 83 05522   |  |   |  |   |  |                                  |  |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR         |  |
| A. Lee  |  |   |  |   |  | Willen  |  | 2-21-83                          |  | 12:30 P          |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                  |  | IF UNDER 24 HRS. |  |
| Male  |  | White   |  | May 21, 1901  |  | 81  |  | MONTHS DAYS                      |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                  |  |                  |  |
| Eldorado, Md.   |  | U.S.A.  |  |   |  | Talbot  |  |                                  |  | MD.              |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                  |  |                  |  |
| Easton  |  | Memorial Hospital at Easton   |  | Ret. Farmer   |  | Farming   |  |                                  |  |                  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS              |  |                  |  |
| Maryland  |  | Caroline  |  | Federalsburg  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Rt. 1, Box 16                    |  | 21632            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                                  |  |                  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  |   |  |   |  |                                  |  |                  |  |
| Josiah E. Willen  |  | Sarah Elizabeth Phillips  |  |   |  |   |  |                                  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                                  |  |                  |  |
| No  |  | 214-18-4317   |  | Rebecca Willen, Rt. 1, Box 16, Federalsburg,  |  | Maryland 21632  |  |                                  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic cardiovascular disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 minutes</u><br><u>1 year</u><br><u>years</u> |  |   |  |   |  |   |  |                                  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>congestive heart failure - (R) lower lobe carcinoma - COPD</u>   |  |   |  |   |  |   |  |                                  |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                  |  |                  |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |                                  |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                  |  |                  |  |
|   |  |   |  |   |  |   |  |                                  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>70</u> , to <u>2/21</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |                                  |  |                  |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | DATE SIGNED   |  |                                  |  |                  |  |
| <u>Albert T. Dawkins Jr.</u>  |  | MD  |  |   |  | <u>2/21/83</u>  |  |                                  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                                  |  |                  |  |
| ALBERT T. DAWKINS JR. M.D.  |  | Route #3, Box 127 Easton Maryland 21601   |  |   |  |   |  |                                  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                  |  |                  |  |
| Burial  |  | Feb. 24, 1983   |  | Hillcrest Cemetery  |  | Federalsburg, Caroline, Md.   |  |                                  |  |                  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |                  |  |
| Frankton-Hawkins  |  | Box 43 Federalsburg   |  | MAR 1 1983  |  | John J. Conner  |  |                                  |  |                  |  |

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